STATE OF CALIFORNIA

Department of Industrial Relations

Division of Workers' Compensation

PUBLIC HEARING

Wednesday, August 23, 2006
Elihu Harris State Office Building
1515 Clay Street
Oakland, California

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I N D E X

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OAKLAND, CALIFORNIA

WEDNESDAY, AUGUST 23, 2006, 10:OO A.M.

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DR. SEARCY: Why don't we go ahead and get started. This is being recorded today, just to let you know, and we also have a court reporter.

So, for the record, the regulations being considered today are in Title 8 of the California Code of Regulations, Sections 9792.20 through 9792.23. It's the Medical Treatment Utilization Schedule regulations that we're considering today.

These regulations have already been through the advisory committee, the DWC Forum and through the formal rule making process, which led us up to today's hearing. So we'll be taking comments from all of you.

We're doing it a little differently, and I'll explain that in a minute. We are also taking written comments up until 5 o'clock today. So if you don't speak but would like to submit something to us, you can do that until five today. If needed, we will go out for another comment period, which is a 15-day comment period.

We have also posted a bulletin advising the public of the rule making process on July_7th. A

second bulletin announcing a public hearing was issued on August_9th, and the Division also posted notice of the public hearing on the main page of its web site on August 2nd.

We had heard some comments at our last hearing that people were having trouble finding when our next hearing was, so we've been trying to publicize it a little more. If this wasn't sufficient, just let us know because we take those comments to heart, and we want to make sure that everyone knows about our hearings.

So, my name is Anne Searcy. I'm the Medical Director of the Division of Workers' Compensation. Joining me is Destie Overpeck, the lead counsel for the Division, and Minerva Krohn, the lead counsel on these regulations. To my right is Stephanie Barrett, who is the Deputy Labor Commissioner at DLSE. She will be helping us conduct the hearing today.

Her role will be, as the moderator, will be to keep testimony to the proposed regulations, keep testimony to ten minutes so that everyone will have a chance to speak, and to keep photographers in our designated area. The last time we had some photographers that were blocking other peoples' views, and also their cords were considered to be a little

bit hazardous. We certainly don't want to have anybody injure themselves by tripping over a cord at our hearing. So we're trying to keep anybody with a cord over in this area.

So I'm going to turn it over to Stephanie at this point. You've all probably noticed that we have a sign-in sheet over here. We're doing it a little differently, so you don't have to put your name on two sheets. You can sign in, and by doing that we will send you notice if we do do another 15-day comment period, so that's automatic if you sign your name there. And if you would like to speak, just put a check next to your name. If you decide -- We'll obviously be bringing those sheets up here, so if you decide halfway through that you want to speak and you didn't put a check by your name, just go ahead and sign up again so that we'll know.

Okay. I'll turn it over to Stephanie.

MS. BARRETT: Thank you. Thank you. Is this on? Okay. What I'm going to do is I'm going to call the names of people who have signed up, and when your name is called, please come forward. If you have a business card, it would be nice if you'd give it to the court reporter. If you have a written statement, you can give that to the court reporter as well.

The first name that I have is Mary Foto.

DR. SEARCY: And we're asking you to keep your comments to the present regulations. If you have other comments about subjects that are outside these regulations, we would really like to hear them. And you're welcome to call us or to write to us, and we can give you the address, but we'd like to keep this hearing to the present regulations.

MS. BARRETT: If I find that you're veering off course, I will make a comment and ask you to get back on course. And I'll let you know when your ten minutes are up. And if you have comments that go beyond the ten minutes, please consider writing them down and submitting them prior to 5 o'clock. Thank you.

MS. FOTO: Okay.

MS. BARRETT: Thank you.

MARY FOTO

MS. FOTO: Well, it's my pleasure to be in front of this panel today and to address the Medical Treatment Utilization Schedule. There are a couple of things that I maybe should start with. I'm an occupational therapist, and for the last 15 years have had a practice that was primarily dealing with orthopedic soft tissue injury, work injury related

type things.

I am representing the American Occupational Therapy Association today, and that's an association of over 35,000 members, and we have 3,300 of them that practice here in the State of California, and many of them do work extensively with injured workers.

Occupational therapists use work-related activities in the assessment and treatment and management of individuals whose ability to work has been impaired by either physical and/or emotional illness or injury.

The testimony that we just wanted to quickly bring to your attention is in two areas, and that is, and Dr._Searcy, I'm going to ask you for some prompts here, since I've gone first and I'm not sure -- May I just reference the section, I don't need to --

DR. SEARCY: Oh, that's fine.

MS. FOTO: Thank you. Okay. The first of the two sections that we'd like to reference is 9792.21. And I would like to say first that the American Occupational Therapy Association applauds DWC for including the provision which states that treatment shall not be denied on the sole basis that a condition or injury is not addressed by the ACOEM Practice Guidelines. We are concerned about how the above

provision is going to be interpreted and implemented into actual practice. Will providers need to include that evidence that you speak of with every bill, every claim that's sent in? I mean is there going to be a way that this can be efficient and expedited in some way?

The second concern is will the claims administrator be empowered to determine if the treatment provided is in accordance with other scientific evidence-based medical treatment guidelines that are generally recognized by the national medical community? How is that actually going to occur? I mean how do you envision the process to occur? What if there is a disagreement, as there is today, between those claims administrators and providers of service? And that would be all providers of service. Who is then going to make a judgment call? How is that going to be handled?

The second issue we'd like to raise is, I will say truthfully in a sense it's going to sound self-serving, and perhaps it is, but it's in regard to the Medical Evidence Evaluation Advisory Committee, and it -- in Section 9792.23 you do point out that it might be either an occupational or a physical therapist. And, just for the record, I would

like to state that occupational therapy is in fact a unique and separate profession from physical therapy, and we are not interchangeable. And I think they would say the same thing as well.

AOTA respectfully requests that the committee be expanded, and I know many people will be addressing that probably to you today in various areas, but the committee be expanded to include an occupational therapist with a specialty in work injury. The unique contribution that I feel that we bring to this whole area is the fact that with industrial injuries we work in a very integrated way. From the time we first see someone we're looking for red flags, whether they're emotional or physical, that might make something that looks like a straightforward injury less than straightforward. And occupational therapists really do like redesign and, therefore, job being part of life, life skills. I think that the focus that we would bring to the committee would be a very holistic one in that way, and that's why I propose this.

Occupational therapists do work with all dimensions, as I said. That would be the physical, the cognitive, sensory, motor and psychosocial, whereas physical therapists have a different focus, generally, that's usually on the physical and

functional limitations that are related to musculoskeletal, neurological, cardiopulmonary and tegumentary malfunctions.

That was it. Thank you very much.

MS. BARRETT: Thank you very much.

All right. The next person, forgive me if I've misspelled, mis-say this. It's Tee Fang Chu? I don't know quite -- is there a -- No?

DR. SEARCY: From Woodland Hills?

MR. CHEN: My name is Ta Fang Chen.

DR. SEARCY: Why don't you come forward then. Can you come forward, please?

MS. BARRETT: Would you mind stating your name, first thing. And, for future reference, could you please come forward and state your full name.

DR. SEARCY: And spell it also for the court reporter. It helps them.

TA FANG CHEN

MR. CHEN: All right. My name is Ta Fang Chen. T-a, F-a-n-g, C-h-e-n. I'm from California Acupuncture Medical Association.

Yesterday I faxed a letter into the, to the medical unit. Basically our point is -- I read the Statement of Reason. Point out, at page 35 point out that relates the hand, the department, they list the

ACOEM reference, but ACOEM didn't list any new reference to support clinical control studies. Our, C-A-O-M-A, CAOMA, ACOEM Guideline, we list clinical control study. So our guideline have evidence based, have the results. So ACOEM, ACOEM, A-C-O-E-M, the guideline does not have evidence based, so this is problem here. So we want the medical unit to resolve this issue, because we don't want you -- I mean you say, you say you use ACOEM Guideline, but that is not correct information.

And we also have this commission, from the Commission of Health and Safety and Workers' Compensation Commission, they suggest that include ACOEM Guideline in California medical treatment utilizing schedule. So we still want just Medical Director include acupuncture guideline in the whole thing. Thank you.

MS. BARRETT: Thank you very much.

Would Robert Thayer or Thouyer please come forward. Please be sure to say your name and spell it for the court reporter.

MR. THAUER: Yes. It's actually Thauer.

MS. BARRETT: Thauer. Sorry.

ROBERT R. THAUER

MR. THAUER: Good morning. I've submitted some

written comments, but I do have a couple of things I'd like to say at this hearing, and I do appreciate the opportunity to comment on the Medical Treatment Utilization Schedule.

I represent a nonprofit group called the Alliance for Physical Therapy, Rehabilitation and Medical Technology. The members in the endorsing organizations of this alliance are primarily manufacturers and providers of physical therapy, physical therapy devices, home medical equipment and orthotics.

My first comment is on 9792.22, which we believe an additional level of evidence should be included in the hierarchy of scientific-based evidence. I've already provided Ms. Gray with a copy of the Code of Federal Regulations regarding food and drugs, medical devices and the determination of the safety and effectiveness of medical devices by the Food and Drug Administration. And under Section 860.7, the U.S. Food and Drug Administration Center for Devices and Radiological Health reviews devices for safety and efficacy. It should be noted that the reviewers are scientists with the appropriate scientific credentials to make determinations regarding the devices submitted to the various panels for FDA approval. FDA protocol

clearly demonstrates that the federal government evaluates the scientific evidence to make a determination of safety and efficacy for the benefit to health from the use of the device for its intended use and conditions of use. We would hold that the U.S. federal government approval to market a medical device as safe and effective provides prima facie evidence that the device is appropriate when prescribed for the indications for use. FDA approval for medical devices clearly meets the standard in SB228 as nationally recognized scientifically based medical evidence and, therefore, should be highly ranked in the hierarchy of evidence described in 9792.22.

Secondly -- That's my most important point, by the way, since most of our members are medical device manufacturers. Secondly, we believe that the definitions quoted in 9792.20 focus more on an academic approach to the practice of medicine. Qualifying evidence only derived from articles published in peer-reviewed journals dismisses medical texts, medical school training, developing technologies and procedures, unpublished studies and findings, and effectively negates community standards of care if they are not based or cannot be proven to

be based on an analysis of peer-reviewed literature. Physicians practice medicine. Not all medical practice is grounded in use of guidelines. And, even so, guidelines in medical literature are often conflicting. Payers in group health and Medicare pay benefits for many practices and community standards of care that would be effectively denied under this restrictive hierarchy of evidence.

If ACOEM Guidelines, which by its own admission, were or are often consensus based and they're to be given presumption, then other consensus based or non-scientific evidence, e.g., or, for example, standard of care in the community, expert opinion, payer approval for treatment, should have credence in the hierarchy of evidence.

I would like to also -- I would add the alliance was represented at the RAND stakeholder meeting, and one of the things that was pointed out by Dr._Scott at that meeting was some of the restrictions she was under in evaluating treatment guidelines. Her mandate, I believe, was to look for comprehensive sets of treatment guidelines, as opposed to individual guidelines from medical specialty societies. And I believe, at least I hope, going forward, that the panel that's being developed will have the opportunity

to not be restricted into only looking at comprehensive sets of guidelines. For example, the California Orthopedic Association and Dr._Scott of RAND both felt that the North American Spine Society, NASS's guidelines on the lower back were very good, but they were not able to be considered because, obviously, the society only focuses on one major body part.

Additionally, I believe there was a mandate, and, again, I hope this is not perpetuated, that guidelines be updated every three years. I believe that's an unrealistic time frame in that clinical studies and the development of new procedures and technologies often take five to ten years. And, you know, medical societies have a lot of things on their plate and to continually have to go back and update their guidelines is rather restrictive. And I believe that's the reason that the academy, the American Academy of Orthopedic Surgeons, at least it was partially a reason why they withdrew their guidelines from consideration, even though RAND had initially suggested that they be utilized.

Last, but not least, and I did skip some of the things that I had sent to Ms. Gray, is the lady that first spoke mentioned about the concern in 9792.21

about -- I applaud also the acknowledgment that if it's not in ACOEM, you can't use that as a basis of denial. But one of the things we're seeing, and I would like to see addressed, is that some payers are applying an ACOEM comment or treatment indication for one body part to another body part where that particular treatment is not mentioned, and I think that's inappropriate that they're generalizing that if there's a comment about a modality or a treatment relative to, say, the knee, they're putting it on the shoulder, the back, the hand, et cetera. So I'd ask that the Division address that.

So I thank you very much.

MS. BARRETT: Thanks. I'll say the last name first, it's Wong, and I think it might be either Tim or Lung Wong.

Please say your name as you -- Please. Please state your name. I'm not sure I got it correct.

LUN WONG

MR. WONG: My name's Lun Wong, L-u-n, W-o-n-g.

MS. BARRETT: Okay. Thank you.

MR. WONG: My English not very well. Can I use my friend to interpreter for me?

MS. BARRETT: Yes.

MR. WONG: Please.

UNIDENTIFED INTERPRETER: I am going to translating for him.

DR. SEARCY: Thank you.

INTERPRETER: He was injured doing the work on April 4th of 2001.

First, there was no disagreement that the company that he worked for already agree that he was work-related injury, and the insurance company still has to send him to the doctor they appointed to, but not his choice.

DR. SEARCY: We can bring a chair over to him. Would that be helpful?

UNIDENTIFIED SPEAKER: This is sick. What do workers have to go through to get help here?

INTERPRETER: But the doctor that appointed by the insurance company won't treat him when he went there. The reason is when he was injured he was driving his own car. But the company he work for, they don't have company's car and company already said that's work related.

He went to see his doctor, spend about six thousand something dollars, and the insurance company won't reimburse it.

Five years later now the insurance company said he still owe the insurance company eight thousand

seven hundred something medical expense.

There is a CIGA plan they want him to join. He wants to know if he join, after he join the CIGA plan, will the insurance company won't ask him for eight thousand something dollars.

He know the answer is no. And the insurance company only want to use it as an excuse that he won't get a life-long treatment for his condition.

MS. BARRETT: Okay. Sir, the hearing today is to discuss the regulations that have been enumerated. Your concerns are very important and --

UNIDENTIFIED SPEAKER: It's disgusting, though.

MS. BARRETT: Yeah. And, actually, what you can do is you can contact the Information and Assistance Unit, and they have the answers for you there.

UNIDENTIFIED SPEAKER: He's giving testimony now.

DR. SEARCY: That's okay, sir. We're just trying to let him know that he can continue testifying. We're not trying to break into it. But it seemed like they were asking a question where they could go, and we were just trying to answer his questions.

MS. BARRETT: Yes.

DR. SEARCY: So there are Information and Assistance officers available around the state, and we can give you that information afterwards.

UNIDENTIFIED SPEAKER: He said he went there. He tried to get advice.

DR. SEARCY: Why you don't you let him tell us.

UNIDENTIFIED SPEAKER: Well, you stopped him.

MS. BARRETT: Have you signed up to talk?

UNIDENTIFIED SPEAKER: Yes, I've signed up.

MS. BARRETT: Okay. Very good.

INTERPRETER: Yeah. He does appreciate your information about the assistance information.

He know the lawyers will, might be able to deal with this case, but he already, he's totally disappointed about the law system of United States. His impression is the lawyers are all legal robbers. The court already make the decision. He doesn't know what the rest of his life will be.

MS. BARRETT: All right. I'm not sure what he said, but it sounds very emotional.

INTERPRETER: Yeah, he just wants to get help from the society.

MS. BARRETT: Thank you very much for testifying. I'm sorry about your pain, but is there anything else that -- is there anything you would like to discuss concerning the regulations presently before us?

UNIDENTIFIED SPEAKER: That's obvious, the regulations are broken down.

INTERPRETER: He has prepared his speech, but now he's all confused by the pain.

MS. BARRETT: Well, if you have anything in writing that you would like to submit, we'd definitely accept it. I'm going to have to call the next speaker at this time.

INTERPRETER: He wants to know for the -- like to repay for his injury is it according to the W-2 form or according to his own salary?

DR. SEARCY: That goes outside of my expertise for sure and really the purpose of this today. So, we can give you -- Susan I think is here somewhere. We can give you the number of the I and A officers who would be very helpful for him. They're spread throughout the state, and they can sit down and talk to him on the phone or in person and give him the kind of advice that he might need. So --

MS. BARRETT: Again, thank you very much for coming in.

I'm going to have to -- I'm going to have to call the next speaker at this time. We appreciate you coming in.

DR. SEARCY: Yes. Thank you very much.

MR. WONG: Thank you for everybody's support. Thank you.

MS. BARRETT: Okay. Thank you. Todd McFarren. If you wouldn't mind saying your name, I would appreciate it. Thank you.

TODD McFARREN

MR. McFARREN: Todd McFarren, M-c-F-a-r-r-e-n. And I'm here today representing the California Applicants' Attorneys Association. We certainly appreciate the opportunity to address the proposed regulations on Medical Treatment Utilization Schedule re-adopting the ACOEM Guidelines as presumptively correct for acute as well as chronic conditions. As many people realize, medical treatment guidelines properly understood should ensure that injured workers receive the care that they need to cure and relieve from the effects of their injuries. It should not be conceived as a cost-saving device. Cost savings will result from correct care delivered in a timely manner. But cost savings as a result of arbitrary rules terminating medical treatment simply externalizes the costs to private health care coverage, to government, and most of all to the injured worker himself or herself and their family. The legislation -- the Legislature adopted ACOEM only as an interim step, sight unseen, prior to publication. The RAND study commissioned by the Health and Safety Commission

concluded that California would be better off starting from scratch, or RAND suggested that the state patch multiple guidelines together into a coherent set. ACOEM was conceived only for acute conditions, not chronic ones. Sure it may apply to some chronic conditions but not by design, just by chance. ACOEM frankly enjoys no scientific validity, even with respect to acute conditions. It is, as it says, a guideline. It's guides. It's an attempt to orient the treating doctor. It's more like a compass than map quest. It allows doctors to apply their clinical judgement against the backdrop of the guideline. It's not designed as some inflexible administrative rule that should be given presumption. By applying ACOEM to chronic conditions when the guide itself states it is for acute conditions only gives rise to a sort of Alice in Wonderland kind of a feeling. I fear the contraction could explode some of out judges' heads if we're not careful. We ask that you reject mechanical medicine and Kafkaesque proposals. There is a pragmatic way to proceed that protects the carrier's concern to pay for only necessary treatment and the injured worker's right to receive the care he or she needs.

In July of '05 Illinois rejected any one

particular set of medical treatment guidelines including ACOEM and referred instead to, and I quote, "Standards of care or nationally recognized peer-review guidelines as well as nationally recognized evidence-based standards." Conflicts could be resolved by the hierarchy of medical evidence. This way doctors must still comply with guidelines, peer-review and evidence based, but have the flexibility to treat the patient as an individual.

Let me just make a few other points if I may with respect to 9792.21 and 9792.8 which addresses the idea that treatment shall not be denied based solely on, and then it uses in one section condition or injury and then in another section treatment. This should be harmonized it seems to me. That we should be talking about treatment not about conditions and injuries. They're very quite different concepts.

On that note, I thank you for the opportunity to speak.

MS. BARRETT: Thank you very much. Okay. Would England please come up. I'm sorry. There was only a last name or a first name. If you have a written statement you're welcome to --

WILLIAM ENGLAND

MR. ENGLAND: No.

MS. BARRETT: And if you wouldn't mind saying and spelling your name.

MR. ENGLAND: My name is William England, and I don't know which section of ACOEM I'm doing because all of my denials just say ACOEM. They don't say which section I'm being denied under. I have here one denial where it says diagnosis unknown. Yet CorVel has been paying for the services required. The doctor wants to do a re-evaluation of my throat, but this doctor says well I don't know what's wrong with him because CorVel doesn't, obviously doesn't send all of the information to him. It says surgery unknown. Yet they paid for 54 days of my being in the hospital, but they say they don't know about it. I'm being denied over here for an EMG when CorVel authorized it, myelogram and a CAT scan. The doctor wanted all three because the myelogram and the CAT scan by itself is useless without the EMG, but they deny it. Why? Because of ACOEM. And another section over there and a third section. But nothing -- never do they specify chapter and verse. A good number of my denials come back from CorVel without anybody saying who denied it. Just denied. They don't send the information. I can't come up here and say I don't approve of this section here because I don't know which section I'm

being denied on. I'm just being denied on this whole blanket thing. That man was just speaking about chronic illnesses. I have several injuries. Every one of them has been denied initially until the attorneys have taken it to court. This was before this ACOEM thing. Now with ACOEM they're denying everything. They've denied therapy that three doctors have recommended. A doctor who's never seen me, has no idea who I am or what I am, and I have no idea what information he's denying me on, denies. And yet there's no recourse except to bring the attorneys to take it to court. Now granted this thing was set up for the protection of the insurance company, but shouldn't some consideration be given to the worker. Everything that I have is work related. Everything's been documented by x-rays, by other diagnostic tools, by 54 days in the hospital. I went in for a cervical operation. I was supposed to be out in three days. I had an allergic reaction that caused a swelling in my throat which still hasn't been cured. I've lost almost complete use of my right arm. These things are ongoing. The doctor wants to fix them, but it keeps being denied. Everything is denied. When I first went in, my hearing aids were denied even though they had the recommendation until it went to court. How

can we as a worker address your particular sections of ACOEM when we never know what section we're being denied under. We don't have a clue as to what it is other than denied because of guidelines. And your guidelines aren't written in stone because they're guidelines, and yet you want to turn around and make these things permanent. Isn't there any compassion for the injured worker or is it all dollars and cents for the insurance company? I know that's a rhetorical question that you're not in a position to answer, but how can I address whether or not I approve of you putting in these sections if I don't know what they are? You don't tell us. The insurance companies never tell us. CorVel never tells us. Gallagher Bassett. Everything that the doctor orders, Gallagher Bassett says review it. As soon as CorVel reviews it, they reject it.

That pretty much summarizes the whole thing. I mean I can go on to four operations on this shoulder, one operation on this one. Carpal tunnel on both arms. Two cervical spine operations from which I'm still trying to recover, and yet everything all along has been denied. I don't know what else to say other than, if you want us to have a voice in these section whatever and whatever, publish the section whatever

and whatever and put it out to the people so that the people in turn, who in theory are supposed to be running this country, have a chance to say something about it. Thank you for your time.

MS. BARRETT: Thank you very much for the testimony.

DR. SEARCY: Thank you for your testimony. I'd just like to point out for you, sir, so that you'll know that ACOEM, we made sure because we do want ACOEM to be available to people. So, it is in every I and A office and available for public to look at. So, you can go into any I and A office and look at a copy there. It's also available in most medical schools, which I'm not sure where you live, but between the two of them hopefully you can find it.

The other thing is that, when they deny in our utilization review regulations, when a group denies it, they're not supposed to just state that it was in ACOEM, but they should give you, the insurance company or the U.R. organization is supposed to give you what part of that is being used to deny it because we understand that you don't have it necessarily at your home. So, they're actually supposed to copy that portion of it and send it to you and, if that's not happening, you should go ahead and contact our

office.

MR. ENGLAND: It's not happening with CorVel. I must have 50 rejections from CorVel, none of which has ever described chapter and verse. Most of which are never signed. Most of which don't even refer to what doctor. It is just a blanket denial with whatever reason is denied.

DR. SEARCY: Well, let me say again, why don't you go ahead and send some of that into us and we'll take a look at it. It's actually a slightly different subject in that that's our utilization review sanction guidelines, but go ahead. I mean I think it's very important for you to understand that you can send that into the Medical Unit in this building, and we'll take a look at it. We're not the ones who solve your problems you've already -- as far as that goes through the judicial system, but if a company isn't following the rules, we'll contact them and remind them of the rules and take it from there, and that's also what our sanction guidelines are for, in our sanction regulations. So, please send it into us.

MR. ENGLAND: Where would I get that address?

MS. BARRETT: I can give that to you. It's -- do you have -- wait one second. I'm sorry, ma'am. I'm going to call out the next name. I'm not sure if

yours is actually the next name.

UNIDENTIFIED SPEAKER: Okay.

MS. BARRETT: It might be, but if you wouldn't mind having a seat, I'll be right with you.

Would the next person -- I think it's -- is it Rachel Smith or Rahel Smith?

RAHEL SMITH

MS. SMITH: Rahel Smith.

MS. BARRETT: If you wouldn't mind saying and spelling your name. If you have any written information, you might want to give it to the court reporter.

MS. SMITH: I want to, yes.

MS. BARRETT: Okay, very good.

MS. SMITH: My name is Rahel, R-a-h-e-l, Smith. I serve as Director of Human Resources for a small business in San Francisco, and I've held similar positions for other Bay area companies over the past ten years. I'd like to vehemently state that many small business owners who care about their employees are not pleased with a system that does not provide adequate coverage to employees injured at work. Owners who care about their staff are displeased and disappointed with a system that does not adequately ensure that their employees are taken care of.

Businesses purchase workers' comp insurance not only because they're mandated to do so but also because it gives peace of mind to those who want to take responsibility for injuries caused within their workplaces.

I would also like to comment as an employee injured at work. I was injured in 1997, and the case settled in 2001 to include future medical. As I have a chronic injury and permanent disability rated at 36 percent it is unsurprising that my condition requires ongoing treatment. However, in 2004 the insurance company stopped approving ongoing treatment which had been enabling me to continue working pain free and with reduced symptoms. The justification for stopping was that treatment wasn't outlined in ACOEM. Since 2001 the insurance company, State Comp Insurance Fund, has repeatedly quoted ACOEM as justification for denial of treatment despite the fact that ACOEM is clearly designed for treatment only during the first 90 days. Both the treating physician and the QME have repeatedly recommended the treatment but the insurance company -- do you need me to stop?

MS. OVERPECK: Thank you. I have to change tapes. I'm sorry.

(At this point Ms. Overpeck changed tapes on the

recorder.)

DR. SEARCY: Thank you.

MS. OVERPECK: Thank you.

DR. SEARCY: Sorry for the delay.

MS. SMITH: Thank you. So, I'm in a situation where both my treating physician and the QME have repeatedly recommended the treatment, and the insurance company continues to seemingly blindly quote ACOEM. Unlike the person who spoke before me, I actually do have specific citations, but they frequently do not apply to the appropriate areas. They will quote from low back area. I have no low back injuries. They will quote things out of context, and they will quote things that actually, when I go apply ACOEM Guidelines, when I hunt them down in the law library and spend dollars making copies of them, which the insurance company refused to reimburse me for though they are supposed to provide me with copies, they actually suggest that the treatment is entirely appropriate. It's completely ridiculous. As an unrepresented worker it's really, really hard to come up against this. If one looks at the guidelines and algorithms in ACOEM, they clearly do not apply to someone in my condition with a chronic injury and a permanent disability. But they're being used as

though they do. They're being abused and misused. For example, algorithm 8-2 on page 188 of ACOEM recommends treatment for quote "Workers with neck-related activity limitations greater than four to six weeks but less than three months duration." I'm clearly beyond the three month duration so this does not apply. In the bottom right of that algorithm ACOEM's only answer to recovery, question mark, is yes, and this does not apply to a patient with an ongoing disability, a 36 percent disability. I believe that presumptive correctness of a treating physician is more appropriate as the system used to indicate. If you were to adopt ACOEM, you would be doing a great justice to set parameters limiting ACOEM as applicable to injuries only for the first 90 days. I really implore you to be very clear about this so it can't be misrepresented by the insurance companies and misused.

While there's a chapter on chronic pain, it's primarily about how to prevent pain. That chapter does not address chronic injuries or how to handle ongoing medical treatment for a patient who has a permanent disability. Please do workers the justice that they deserve and please clearly issue appropriate recommendations. Clarify insurance companies are

obligated to continue providing treatment to permanently disabled workers, and this treatment will frequently fall outside of ACOEM.

Thank you for taking the time to hear these comments. I appreciate the many hours you are putting into this effort, and I hope that you'll keep the injured worker perspective in mind. We frequently don't have the same resources available to us as insurance providers do, and since ACOEM has been adopted, the insurance companies have been seemingly deaf to all requests.

There are four points that I would like to make prior to wrapping up. First, I would like to say that it's taken literally years since the insurance companies started denying treatment on the basis of ACOEM until a hearing occurred. So, the system set up to presumably provide recourse to workers do not work. So you might be setting up something that in theory works but in reality it doesn't. These delays are difficult for patients who need treatment to keep functioning. These delays in my experience have been much worse since ACOEM was adopted.

The second point is that I'm in a distinct bind regarding chiropractic treatment. I don't know if this applies to other providers, but regulations

prevent chiropractors from accepting payment directly from a payment -- from a patient if the provider knows there's a workers' comp injury. I am no longer allowed to say I think this works, my treating physician thinks this works, the QME thinks this works and helps, and the person is not allowed to treat me. So I can't get treatment. I can't even pay for it out of pocket. If I did want to get chiropractic treatment and pay for it out of myself, I need to go to a different provider and mislead them as to the source of my injury. The current system not only refuses to pay for treatment but also prevents our independent access to treatment which seems ludicrous. So, again you're setting up systems that you think might work, but in actuality they don't.

The third point is that I submit to you a copy of an insurance utilization review which is two pages, and my response to it which is six pages, and you can review this in written format. The UR uses ACOEM as a justification for denial of coverage, but as I mentioned at the beginning the UR's use of ACOEM is completely out of line with my actual case. They cite irrelevant sections. They take ACOEM quotes out of context, and they are thoroughly illogical. They just don't make sense. It's frustrating and disappointing

that the insurance company is allowed to behave this way and that patients have no recourse. Please take into account the misuse of ACOEM when considering whether to implement it as a presumptively correct document on an ongoing basis.

The fourth point is that I'm an unrepresented worker trying desperately to do this on my own, and the Information Assistance Officers have been not only entirely inaccessible but completely useless. So, again that system that you have supposedly set up as a safeguard for workers is not working. Trying to get a callback is hard. I've actually spoken with someone and said, you know what, I'm in the middle of -- I'm in the middle of a work meeting. Can you call back at 3 o'clock? Would that even work? Because if necessary, I'll stop, and they said no problem we'll call you back. No call. I've called multiple times. If they don't happen to reach me when I'm there, they don't call back, and I'm carrying my cell phone around and frequently available. It's just not a system that works.

So, thank you again for your time, and I appreciate what you guys are doing, and I hope that the end result of this will be a system that actually serves to take care of workers who are injured and

have permanent disabilities.

MS. BARRETT: Thank you very much. Okay. The next person is with the Injured Workers Association, Maria, and I'm sorry if I get your last name wrong. Is it Lozada? Injured Workers' Association. Okay. All right. Steve Zeltzer.

UNIDENTIFIED SPEAKER: He just went to the bathroom.

MS. BARRETT: That's okay because I'll come back to him as well. The next person is -- forgive me, is Dena Padilla?

MS. PADILLA: Dina Padilla.

MS. BARRETT: Dina Padilla.

DINA PADILLA

MS. BARRETT: If you wouldn't mind saying and spelling your name, I'd appreciate it. Thank you.

MS. PADILLA: Sure. My name is Dina, D-i-n-a. Padilla, P-a-d-i-l-l-a.

Well, first of all, I'm sorry to see Carrie Nevans isn't here. I wanted to ask her a question. Maybe you can -- what's she doing up at the Capitol since the last testimony we all provided on June 29 of this year? It was a hundred sixty-one pages, which was hard to find by the way. Okay. I did some research on ACOEM Guidelines. So, I'm going to read

to you pretty much what I discovered and then also a few little points of my own.

ACOEM Guidelines and utilization review, utilization review comes out of the ACOEM Guidelines, was inserted into the legislation of SB899. It's also a national organization. What I came out with is that it's not national, it's international. It's comprised of over 6,000 international health care staff, which include utilization review, which comes from large corporations such as Dow Chemical Company, and I don't even know how they can practice medicine in the State of California. It's my understanding that people who treat people here in California have to be California licensed.

ACOEM violates, at this point to me, the laws of the state, and that was with the passing of SB899 by Governor Schwarzenegger and the legislators who co-authored the bill. The insurance carrier adjusters have denied medical benefits, acting as licensed doctors, which is against the laws of the state. Now, under international utilization review, SB899, insurance adjusters are being trained to use utilization review for all medical care treatments or visits to treating physicians, and it's unlawful.

And I talked to a CNA Insurance adjuster last

week and this week. She said that all insurance carrier adjusters are going to meetings and they're using utilization review on all medical care claims. So if I go to a judge and he gives me future medical care, those will be either denied or accepted by utilization review. I asked her for the paragraph in SB899, because I read it, and I didn't see in there, that utilization review and ACOEM could be applied to all claims, medical claims care. She said, her name is Gail Stutters from CNA, she said that there's a Labor Code and that SB899 was a summary. So I asked her for the Labor Code. I want to read the Labor Code and where they can have access to all medical claims and overriding the judge's decision of findings and award. I'm still waiting for that.

ACOEM is co-sponsored by Glaxo Smith and Kline, one of many corporations, and is one of the largest global pharmaceutical companies that are conducting testing on genetics and DNA. This pharmaceutical company board of directors from, comes from Great Britain, the UK, and are of British royalty. ACOEM Guidelines present the GNA, genetic DNA information to the Department of Labor and to Washington, D.C., legislators and the President of the United States. These are also investments. These investments are

also in the stock market. ACOEM is also supported by Pfizer Drug.

ACOEM Guidelines were inserted as SB899 to cut off past benefits, ex post facto of all injured workers prior to SB899 and post-injured workers and especially those who are unable to go back to work. How can ACOEM Guidelines and utilization review override a judge's decision and award for any medical care? These same injured workers can only then rely on public programs, cost shifting to the taxpayers after trying for years for their medical care and financial existence.

This is what ACOEM and utilization review is meant to eliminate: Particular repetitive injuries such as carpal tunnel, TOS, low back injuries, et cetera. ACOEM is meant to eliminate the standards of repetitive stress related injuries and disabilities. ACOEM is meant to eliminate disabilities and the rightful compensation. ACOEM and UR is meant to eliminate medical care for seriously injured workers, which I believe is the complete goal, because people who have injuries that could be taken care of over a short period of time don't believe this applies to them, but I believe that's what ACOEM was brought in for. ACOEM is meant to eliminate OSHA standards and

the agency itself, and bring in its own standards unrelated to OSHA or AMA guidelines. ACOEM is meant to eliminate real personal physicians that diagnose and treat injured workers. ACOEM is meant to eliminate any history of workers injured at the workplace.

It's interesting, I talked to a gentleman who was hurt on the job trying to make a complaint to Cal-OSHA. Cal-OSHA said that you had to be in a hospital for 24 hours before the employer makes Cal-OSHA aware of the injury.

ACOEM is a nonprofit occ-med group that claims to be experts by lowering the standards to recognize and treat injured workers. ACOEM is a corporate-backed nonprofit occ-med group that supplies questionable research of human guinea injured worker pigs. I say that because with Glaxo Smith and Kline the biggest part of -- where they got their information, their research, I want to know where they got it, because I believe that they got it from all the injured workers in the last 15 years, and it's bogus research. And for them to be able to sit there and then sit there and make money through Glaxo Smith and Kline. ACOEM corporate guidelines was created to disable all workers so that insurance companies will never, never

have to pay out compensation done to injured workers and that those profits will go to companies like Glaxo Smith and Kline, Pfizer and Dow Chemicals, et cetera, for their own profit-making investments.

The one other little part I wanted to say is -- I'm almost done. This is about professionalism in the worker comp arena. You don't have -- the young lady just prior to me said that I & A availability is non-existent. And I want to let you know that's true. In Sacramento the I & A officer is more gone than she's there, a whole lot more gone than she's there. And to get information, we can't get information. We get thwarted, we get lied to. So the availability of an I & A officer, I don't see where that is, because we have, I can't tell you how many injured workers have tried to contact them in person and by phone to no availability, or little availability.

There's one other point I wanted to make here. Oh, yes. Probably in a worker comp central Carrie Nevans made a statement that the last meeting of June_29th, 2006, was hijacked by injured workers. Well, I want to let you know as an injured worker myself, and many others that I know, we've been insulted, our rights have been trampled on, but when somebody sits there and says that we hijack meetings,

this is a public forum meeting, public hearing. We have a right to speak what we want to speak, and I highly resent anybody saying that meeting was hijacked. Because I'm not a hijacker, I'm an injured worker trying to get my rights taken care of, trying to get the care and trying to help other injured workers. That's what I'm an advocate for. So the hijacking word just really, really needs to go. And if anything else, we've been hijacked. We've been hijacked of all of our rights and our medical care and our benefits and everything else that we were supposed to get under the workers' compensation system.

Thank you.

MS. BARRETT: Are you Mr. Zeltzer?

MR. ZELTZER: Yes, I am. Yeah.

STEVE ZELTZER

MR. ZELTZER: My name is Steve Zeltzer, Z-e-l-t-z-e-r, and I'm chair of the California Coalition for Workers Memorial Day.

I think that what we've seen here from the testimony of workers is that this whole utilization review and these ACOEM Guidelines are a fraud. And what's been perpetrated on the people of California by you, you people and Carrie Nevans, who's afraid to show up here at this hearing, is that the injured

workers are not getting treated and are suffering as a result.

It is outrageous that a Chinese worker who can't speak English nearly collapses cause he can't get treatment, and the insurance company wants to charge him. How do you think immigrant workers feel when they get injured and have to go through your bureaucracy, contact officers about information? How do you think they feel? Who's responsible? The fact of the matter is the ACOEM Guidelines and the ACOEM organization, as a matter of fact, is a pro-corporate, pro-management organization. Are you aware, and should the audience be aware that ACOEM testified against ergonomic standards and supported Bush saying there shouldn't be ergonomic standards in the United States. This is an organization you have as guidelines? Who does this organization represent in California or nationally? We say it represents the insurance companies. That's why workers aren't getting treated. Your whole utilization review is a scheme, a bureaucratic scheme to prevent workers from getting treated. It's not about proper treatment. Workers should be able to go to any licensed doctor in California and get treated for their injuries. That's why we have to get, and this is our position, the

insurance companies out of the workers' comp industry. They have no business. They make money by not treating workers. That's how the insurance companies make money, by not treating workers, and the workers are being severely harmed, their lives are being destroyed, and it's, it's unacceptable and intolerable.

Dr._Larry Rose, the last medical doctor in Cal-OSHA, they removed all the doctors at Cal-OSHA, Schwarzenegger has removed all the doctors at Cal-OSHA in a letter to you. It is important to understand that the American College of Occupational and Environmental Medicine, ACOEM, and the Western Occupational Environmental Medical Association, WOEMA, have always been dominated by corporate employed or corporate practice medicine, MDs, some of their own multi-clinics that are corporations that are well developed in places like central valley of California. Their primary focus is the present workers' compensation arena, change the system, negotiate for higher reimbursement, raise fees, higher fees for cognitive services, written reports and play along with insurance companies by dominating utilization review, diagnosis and treatment decisions, which usually fail to recognize the full degree of

disability work-relatedness and workers injured in the ultimate(phonetic) industry task.

Put clearly, these special corporate interest physicians' organizations put the interests of workers compensation insurance carriers ahead of California's injured and ill workers. This often leaves California's 17 million employees when injured or ill to encounter a non-responsive adversarial workers' compensation system. This is from Dr._Larry Rose, who just retired from Cal-OSHA.

We understand that the Director, Carrie Nevans, is planning to file criminal charges against an attorney because he directed, the attorney said that he was not going to have doctors treat workers unless they contributed to the Democrats. So, Carrie Nevans, your office is directed to sue this lawyer. Why aren't you suing or taking criminal complaints against insurance companies who are having unlicensed physicians make medical practice in California? Why aren't there any criminal complaints about that? Why are non-medical personnel, insurance adjusters, who Carrie Nevans is, that's who Carrie Nevans is, why are they making medical decisions in California? Why are they preventing workers from getting treated in California? Insurance adjusters, not doctors,

insurance adjusters. The whole utilization review guideline system that you have in place is established and set up by the corporate interest, the insurance companies, Warren Buffett and others to prevent injured workers from being treated so they can make billions of dollars in profits. That is what's going on here. And the deaths and the continued injuries of workers here are on your responsibility, on your shoulders and Carrie Nevans personally because you're allowing this corrupt system to operate as it is.

The failure of California to take care of injured workers is leading to these injured workers being cost shifted to the disability insurance. There's been a sky rocket increase in disability insurance from workers' comp claims. There's been, workers are being forced to go to SSI, go on SSI to get their injuries taken care of. Barbara Clark just recently had to have an operation paid for by the federal government because the Seventh Day Adventist corporation would not pay for it, even though it was an injury as a result of her work. There's a massive cost shifting going on.

We believe it's a criminal conspiracy by the insurance companies to cost shift. They're saying to workers like Wal-Mart get your health care taken care

of some place else. They're conspiring. That's what the insurance companies and company doctors are doing. They're conspiring to avoid paying their legally required costs, and they're sending workers some place else, public hospitals. Joe Dowell, who was injured at Lowe's hardware store in San Mateo, they sent him, they either sent him to a public -- he goes to a public agency in San Francisco to get his injuries taken care of. We believe that Carrie, that the department, if it really represented the people of California, would be filing criminal charges against these corporations and insurance companies for shifting costs, for defrauding the people of California, for forcing the public and the citizens to pay taxes because they refuse to pay for their cost. That's precisely what's going on in California. This utility, this utilization review is part of that shifting because it's a means of preventing workers from getting their care taken care of.

Lastly, we want to say that the, the money that's spent here by Carrie Nevans, you have about 30, 40 highway patrolmen outside, you have five or six cars. Who are they protecting? Who are they here for? The injured workers? Are injured workers threatening the State of California? Thousands and thousands of

dollars, maybe 20, 30 thousand dollars is here outside supposedly to protect the people of California. Why don't you use that money to take care of the workers here? Why don't you respond to workers who call your offices and can't get responses, can't get answers to why they're being basically screwed by the insurance companies? Instead, you have the highway patrol here. That's your answer to injured workers. It's an insult, it's a disgrace, and it's only going to get worse because it's a systemic problem.

This ACOEM is an example of a systemic problem. Doctors, licensed doctors in California should be able to treat workers without having to go through a bureaucratic convoluted process to treat workers. And what you're saying with this ACOEM process is that's the way it's going to be. And not only that, even the Commission on Health and Safety and Workers' Compensation is saying the ACOEM Guidelines are not proper guidelines because there are other guidelines that can be used that are more appropriate, and you're ignoring that. Well, whose interest are you representing? Whose interest are you representing? It's the insurance companies that you represent here. That's where these determinations are being made by Carrie Nevans. She's not brave enough to show her

face here, but that's who she's representing, the insurance companies. And we, the injured workers and the public of California are getting sick of it, are getting sick of the insurance company destroying the lives of injured workers and basically ripping off the people of California.

Thank you.

MS. BARRETT: Thank you very much. Is Maria Lozada here with the Injured Workers Association? Okay.

I'm sorry if I mispronounced your name. Is it Naleen Verbeten?

DR. SEARCY: Nileen.

MS. BARRETT: Nileen?

MS. VERBETEN: Nileen Verbeten.

MS. BARRETT: Sorry. I'm very sorry about that.

MS. VERBETEN: Thank you very much.

MS. BARRETT: If you wouldn't mind saying your name. I so totally abused it.

NILEEN VERBETEN

MS. VERBETEN: It's Nileen, N-i-l-e-e-n, Verbeten, V-e-r-b-e-t-e-n. I'm with California Medical Association. I have provided written comments already.

Dr._Searcy, and other representatives of the

Division, thank you very much for the opportunity to speak today. We have a fairly long written testimony. My remarks will be certainly much shorter. But generally, I would like to comment on each section of the proposed regulations.

Many of our speakers preceding me today have already spoken to the issue of definitions as it relates to acute and chronic. We point out that there is no medical evidence to substantiate three months as a break period between one and the other. We are not opposed to the definition, but we, like many previous speakers, are very concerned with the application by the claims adjusters or claims administrators, and fear that there will be great mischief as they look at these issues. We are very concerned that there are many conditions that are persistent, and these conditions are frequently being given short shrift because they don't follow the neat and tidy response that is set forth in the guidelines.

On the Medical Treatment Utilization Schedule itself, we very much appreciate the Division sort of restating the intent that these guidelines are an analytical frame work. They do not constitute a cookbook or literal guide. We do appreciate the Division understands that we are sympathetic with

speakers who have gone forward who suggest that the claims administrators either do not understand that or choose not to understand that. We have many, many complaints where physicians have extraordinarily literal interpretations of these guidelines, and so we have great concern that while they have a very appropriate use when in the right hands, they are clearly not being used properly.

On the manner of the hierarchy of evidence, we do support the hierarchy that has been identified as labels A through C and certainly reinforce that those seem to be appropriate, and we concur with their use. We are somewhat dismayed that level D as ACOEM set forth is not listed. We believe it needs to be restored. There is an enormous amount of medical care that is very appropriate that nobody can contest but has no basis in randomized control trials or strong research that it is efficacious. We just know it is. Some easy examples: There are no random control studies that say removal of a foreign body is superior to leaving it there, but we don't question that. Broken arms, we could just say there's no randomized trials that suggest that setting those arms are an improvement over not setting them, but we don't question that. We can identify with those injuries

and we can appreciate the need to deal with them and deal with them properly. We're very concerned that much of what is being denied now by carriers as not being based in evidence clearly does have substantiation. We believe some evidence of your very own writing in terms of the Initial Statement of Reasons more than adequately stresses the infantile nature of evidence-based medicine and the fact that we do not have any superior sources of information, of guidelines that are addressing the scope of issues that workers are experiencing. So we really do believe we need to go beyond the current ACOEM. While we do support ACOEM, we do not believe that it is sufficient.

In my written comments I provide a rather tongue-in-cheek research paper from the British medical journal that points out with great detail the lack of any evidence to support the proper use or the efficacy of parachutes and call for an open source of volunteers for randomized control trial.

In terms of the Medical Evidence Evaluation Committee, we think this is a marvelous idea and support it. We have provided some material that is used by Medicare in a relatively equivalent committee called the Carrier Advisory Committee, and I was able

to find the Medicare carriers' manual description describing that and offer that as a potential model to investigate as you look at establishing this committee. We are concerned that this committee be properly supported and make sure that there are individuals available to do the research that this committee is going to need, for it will be substantial.

We do request consideration of a couple additional physicians on this advisory committee. We note the absence of a representative from neurosurgery or neurology. I believe that would be an important addition. We also would ask for consideration of a representative from the state medical society. There are many medical specialties that are not represented on this committee. We appreciate that trying to represent them all would not be efficient, and so we would ask that that deficiency be corrected that way. And then in terms of the three -- the three members that the Division would appoint, we would ask that at least one of them be drawn from the medical research committee with experience in evaluating strength of medical literature in terms of the hierarchy that's being used. We think this will assist with deliberations of the committee and assist the Medical

Director as she struggles with these very important issues.

Thank you for the opportunity to comment.

MS. BARRETT: Thank you very much.

Dr._Meredith Saunders, U.S. HealthWorks.

MEREDITH SAUNDERS, M.D.

DR. SAUNDERS: Good morning. I'm Dr._Meredith, M-e-r-e-d-i-t-h, Saunders, S-a-u-n-d-e-r-s. I'd like to thank Dr._Searcy once again and the Division for their ongoing consideration of providers' needs and truly helpful attitude.

The RAND study performed in 2004 revealed that ACOEM Guidelines do not match the Labor Code guidelines of being evidence based on scientific data. As a Regional Medical Director for U.S. HealthWorks, I split my time between patient care and administrative work, and truly the ACOEM Guidelines are not meeting my practice needs, particularly with regard to internal medicine.

I won't take up a lot of time. Some of this is repetitive. Briefly, I specifically recommend that a broader panel of specialty providers, including, but not limited to, neurology, psychiatry, occupational medicine, orthopedic surgery, neurosurgery, internal medicine and physical medicine and rehabilitation be

selected to establish practice guidelines. That will reflect the reality of care from the injured worker.

While a gallant effort, I'm sure, the ACOEM Guidelines leave gaps and actually present challenges to the delivery of expeditious medical care. Denials and delays are occurring that prevent employees, employers and patients from moving forward to meeting their goals. It is my belief that the ACOEM Guidelines were not established for the purpose of utilization review. Indeed, Barry Eisenberg, the Executive Director of ACOEM, has stated that these recommendations are suggestions and not mandates.

Again, I would like the Division to quickly consider broadening the scope of the specialty providers on the board to establish these practice guidelines.

Again, thank you for your consideration.

MS. BARRETT: Thank you very much for coming in.

Is Diane Przepiorski -- I'm sorry.

DIANE PRZEPIORSKI

MS. PRZEPIORSKI: My name is Diane Przepiorski. It's P-r-z-e-p-i-o-r-s-k-i. I'm the Executive Director of the California Orthopedic Association representing orthopedic surgeons throughout California.

First of all, we really do appreciate again an opportunity to be before you here today to talk about the treatment guidelines. And I personally really appreciated the Division's extensive Statement of Reasons. I thought that was very enlightening as to the, really, the thought that the Division went through trying to wrestle with treatment guidelines. And, you know, I think it also is becoming very evident to us all that even our national professional organizations have had a very difficult time struggling with trying to develop treatment guidelines that would be applicable to all care.

I came to the meeting today convinced initially that ACOEM just does not apply to chronic conditions, and you heard that from many speakers, and we just don't see the science behind ACOEM applying to chronic conditions. After the testimony that I heard this morning, I'm really kind of wondering if they're really applicable for the acute stage. And, you know, I just don't think the Division knows at this point. There's so much literal interpretation of the ACOEM Guidelines going on out there whether it's, as Nileen points out, whether on purpose or by design or by accident. I just don't think we even know if ACOEM is being applied correctly for the acute stage. So, to

try to get our hands around that I would urge the Division to take a step back, and we definitely would oppose these regulations applying to the chronic stage. So, we think that language should come out of the regulations. And I really do think it would help to put a time frame around the application of ACOEM. Whether it be the first 45 days, 60 days, 90 days of care, and get a better idea of how that works first before we even talk about the chronic stage. And so the two things I would urge is that there not be a reference or there not be an admonition that ACOEM also applies to the chronic stage, and that I would put a time frame in to give direction to the community as to just what time frame ACOEM does apply to. And we would suggest 60 to 90 days.

On the second part on 9792.23 we very much support the creation of a medical advisory committee. We think this is critical to help the Division work through some of the problems that are being expressed here today, whether you're talking ACOEM or other treatment guidelines. You know, I'm seeing members that get the long rendition of ACOEM citations but then they throw in guidelines from other companies as well, and, you know, to expect the treating physician to respond to each and every one of those points, many

of which are not really relative to the actual treatment of and the condition of that patient is just unreasonable, and it's not going to happen. And particularly since there's no reimbursement to the physician to go through each and every point. So, we very much support another body that could help provide some review of the medical literature or the consensus-based medicine that does work and would like to expand on comments that CMA made about this Medicare model. Medicare and National Heritage here in California has for years convened. I think it's at least twice a year. It may be a little more frequently. What they call a California Carrier Advisory Committee. It is composed of a representative from each of the recognized medical specialty organizations, and I would agree that for workers' comp that would not necessarily be necessary or appropriate. It should just have one representative from each of the medical society, medical societies that treat injured workers. So, you wouldn't need necessarily a pediatrician and some of the other medical specialities on it. But each person, the state-wide association appoints this person. So, the onerous isn't on the Division to try to magically come up with the most appropriate

orthopedic surgeon or neurosurgeon or whatever. It's up to the state orthopedic association to appoint that person. In addition, CMA is represented on that CCAC and, I think, they do add good input not only from a state-wide but from a national input because they work more with CMS on a national level. I would even go so far to say as I think it would be appropriate to put a representative from the payer community, whether it be a workers' comp carrier or representative from the self-insured employers. I think it would be critical that it be their medical director so that they can really provide input on medical issues, but I think that this structure should represent all the parties that are involved in the workers' comp arena. Otherwise the Division is just going to be, as you've already heard different people saying, there should be different specialties represented and there's no right answer to that. You might as well involve them all. The key I think to the committee that Medicare has formed is that, when there is an issue under consideration, they form a subcommittee of the specialty societies of the specialties that are directly affected by the policy. If it's low back, they get together the providers that are part of low back, whether it be orthopedic surgeons, neurosurgery,

chiropractor, whatever specialty is involved. They start with a draft of the policy that National Heritage provides, and I would think that would be most productive here as well. And then DWC would convene the subcommittee and let the medical experts comment on the draft proposal. And once there's some consensus of this draft, and we believe there should definitely be a written document that comes out of this work, it ultimately would provide the best direction to the Division. It would provide the best direction to the carriers, and to the medical providers if this advisory committee produces a written document that everyone can see. We think the subcommittee should present then their work to the advisory committee as a whole. The advisory committee as a whole should be a public meeting where people can see the process work and see the deliberative nature of the process, and I can tell you that it's worked well in the Medicare world. Perhaps the issues are maybe not quite as contentious in the Medicare world, but I think it would be a good avenue and good way for the Division to hear from the experts in the medical community.

Finally, I think this subcommittee should be allowed to bring in experts, and that could be at the

discretion of the Medical Director. You know it would be impossible for us to appointment an orthopedic surgeon that we would call an expert in all the different musculoskeletal areas. So, I think it's just most productive and you would come up with the best work product to just get the experts involved. Let them hash out the medical issues and try to reach agreement, and then present the document to the CCAC as a whole. I think it's in line, obviously it would need some support from the DWC, I think it's in line with what you're proposing in the regulations, but it just gives a little broader representation which we think would be critical to reaching agreement on these issues.

Thank you very much.

MS. BARRETT: Thank you very much. Ted Pribe. It's the National Oriental Medicine Accreditation Agency. I'm so sorry. Priebe. How do you say your name?

MR. PRIEBE: Priebe.

MS. BARRETT: Sorry. Priebe.

TED PRIEBE

MS. BARRETT: If you wouldn't mind again saying and spelling your name.

MR. PRIEBE: Certainly. I appreciate the

opportunity to speak today. I represent the National Oriental Medicine Accreditation Agency.

MS. BARRETT: One minute. Your name is spelled, is it P-r-i-e-b-e?

MR. PRIEBE: Correct.

MS. BARRETT: And it's Ted, T-e-d?

MR. PRIEBE: Correct.

MS. BARRETT: Thank you.

MR. PRIEBE: I'm the Executive Director of NOMAA, which is the National Oriental Medicine Accreditation Agency. We provide standards and criteria for evidence-based first professional entry-level doctorate degrees in this country. I've also been a practitioner in California for 25 years as well as I've worked on most all of the evaluation committees for workers' comp and utilization review for the past 15 or so years since 1990. Sorry. We -- it's unfortunate that the ACOEM Guidelines don't have to meet the same requirements that all the specialties are going to be required to meet as far as the evidence-based requirements outlined in the new regulations. This has set up a most difficult problem in the area of acupuncture or healing therapy in that that's been effectively removed from the system over the past two years since the adoption of ACOEM. We've

only received denials from every insurance company and every utilization review company in the state. There's very few of us that still practice within the work comp system based on functional improvements which we have to show, just as other medical specialties do. And I know this affects all the other medical specialties as well as ours in relation to these guidelines when we have to meet a different standard than ACOEM does even though they're presumptively correct in law. Especially in my field, there is no evidence-base supplied by ACOEM Guidelines. Our guidelines have been rejected by ACOEM in a number of ways, not just through the utilization review process, but also even -- even as a participant on some of the utilization review committees which I have been involved in, especially the last one that was set up. In that it was dominated primarily by ACOEM and insurance providers, and we had no real input or interchange into the review at all.

I don't want to take up a lot of time because I know other people have things to say.

Ms. OVERPECK: Can you stop for a second please.

MS. BARRETT: While we change the tape.

(At this point Ms. Overpeck changed the tape on

the recorder.)

MS. OVERPECK: Thank you. All right.

MR. PRIEBE: Thanks. Guidelines are just that. They're supposed to be guidelines to guide you to practice medicine, and medicine is a practice. We all practice in our own specialties. The practice of medicine is not a science. It's the application of this science to get the best results in order to come up with guidelines that lead you to better outcomes. You can't do that when you have guidelines that are presumptively correct that don't meet that standard. So, I'm hoping that with the -- this new medical review process that we get an opportunity to finally change that direction and go up towards real evidence-based medicine which will benefit the outcomes of patients. Thank you.

MS. BARRETT: Thank you very much.

DR. SEARCY: We're just discussing lunch, which is an important subject too. So, what we're thinking, it looks like, if we go at the present rate, that we probably have another two or three hours of peoples' testimony. So, we would like to go a little bit longer, maybe half an hour or so, and then take a break. So, a break is coming. Just wanted to let you know.

MS. BARRETT: Peggy Sugarman.

MS. OVERPECK: She just walked out.

MS. BARRETT: Okay.

UNIDENTIFIED SPEAKER: Will everybody get a chance?

DR. SEARCY: Oh, definitely. We will stay for the whole time. Everyone will have an opportunity for sure.

MS. BARRETT: All right. Francisco Plasencia.

FRANCISCO PLASENCIA

MS. BARRETT: If you wouldn't mind saying and spelling your name.

MR. PLASENCIA: My name is Francisco, just like San Fran, Plasencia, P-l-a-s-e-n-c-i-a, and I'm with the VotersInjuredatWork. I came in support with Peggy.

All I really have to say is I agree with what everybody, all the injured workers are saying. We're being denied everything; medicine, chiropractic, you name it, and we hope that you do something about it. Please, we're asking. Thank you.

MS. BARRETT: Thank you very much. Don Schinske.

DON SCHINSKE

MR. SCHINSKE: Hi, I'm Don Schinske. I'm here today on behalf of two organizations. One is WOEMA,

the Western Occupational Environmental Medical Association, which is the western region component society of ACOEM. I'm going to defer those comments from WOEMA to Dr._Schumann who's going to talk about the various ways in which ACOEM is enhancing its guidelines and their usefulness hopefully to the system. I'm also here today to deliver a couple of comments from the California Academy of Family Physicians. There are seven thousand practicing family physicians in the state of California. A typical F.P. will devote 10 or 15 percent of his or her practice to work comp cases. We believe that represents -- they're probably the most heavily represented specialty within the workers' comp system I believe. As a result I think that, you know, they serve as a P.T.P. on a -- P.T.P.s on a significant number of work comp cases, and I think a seat should be rightfully designated as P.T.P. on the advisory committee.

Our second request is that one of the seats has been mentioned earlier be dedicated to an expert of no particular affiliation who is simply an expert on a clinical research. Thank you.

MS. BARRETT: Thank you very much. Peggy Sugarman. Is that right? Very good. Thank you. If

you wouldn't mind saying and spelling your name I would appreciate it

PEGGY SUGARMAN

MS. SUGARMAN: Thank you. Sorry I missed my call. My name is Peggy Sugarman, S-u-g-a-r-m-a-n. I'm here on behalf of VotersInjuredatWork.org. And thank you for the opportunity to comment on the Medical Treatment Utilization Schedule.

VotersInjuredatWork.org is a non-profit organization that represents the interests of employees injured in the service of California's employers. And just to talk about medical treatment, maybe it's obvious, but all injured workers regardless of whether they lose time or not receive medical treatment under the workers' compensation system. So, of course, the medical treatment guidelines and the delivery system is of paramount importance to the workers' compensation system. California has been employing the ACOEM Guidelines on an interim basis as the presumptively correct standard of medical treatment for about the last year and a half, and prior to that for several months as well before they were not the presumptively correct guideline. And given this length of time we've had a chance to see how the guidelines have worked. In addition there's

been litigation challenging the applicability of the guidelines, and it has shed light on some very relevant issues. So, the -- we now are proposing to permanently adopt ACOEM as the presumptively correct standard for treatment despite a very lackluster evaluation from the RAND team who reported in November of 2004 that all of the guidelines that they reviewed and I quote "barely meet standards" unquote. Stakeholder interviews, when that report was being prepared, confirmed that the ACOEM Guideline has quote "been applied to topics that it addresses only minimally or not at all." For example, chronic conditions, acupuncture, medical devices, home healthcare, durable medical equipment, and toxicology. So, to deal with these identified deficiencies the RAND report suggested that ACOEM be adopted along with other guidelines, and at the time the AAOS guidelines were recommended. We understand those have been withdrawn. But in addition to additional guidelines they recommended that the state proceed as quickly as possible to deal with certain areas where they felt that ACOEM did not perform well. Those areas are physical therapy of the spine and extremities, chiropractic manipulation of the spine and extremities, spinal and paraspinal injection

procedures, magnetic resonance imaging of the spine, chronic pain, occupational therapy, devices and new technologies and acupuncture.

So, since that time, and again we're talking November of 2004, there have been a lot of problems with the treatment delivery system. Some, of course, are the result I think of utilization review delays and improper use of the ACOEM guidelines. But the problems that were reported to the RAND team in 2004 still are continuing today. And I believe these regulations do little to address those issues. Specifically, we are completely opposed to section 9792.22 that makes ACOEM applicable to chronic conditions. We have seen the newsletter that ACOEM has put out that suggests that guidelines are applicable. However, there's a big difference between using ACOEM as a guideline to suggest possible medical approaches to a work-related injury and making it a presumptively correct standard of care for chronic conditions. These are two entirely different concepts.

The RAND research highlighted problems with ACOEM being applied to chronic conditions. There are also current cases where the applicability of ACOEM was successfully challenged in the courts. In Hamilton

versus State Compensation Insurance Fund the WCAB denied reconsideration of a judicial award of medical treatment alleged by the defendants to be contrary to ACOEM. The trial judge determined and the WCAB denied reconsideration that ACOEM Guidelines apply only to the treatment of acute injuries. They based their decision on the language of the ACOEM Guidelines. So in Hamilton the judge referred to the statement in Chapter 12, low back, that clearly states, quote, "Recommendations on assessing and treating adults with potentially work-related low back problems, i.e. activity limitations due to symptoms in the low back of less than three months duration are presented in this clinical practice guideline." ACOEM makes a similar statement in Chapter 13 governing knee complaints. I'm going to quote. "Recommendations on assessing and treating adults with potentially work-related knee problems are presented in this clinical practice guideline. Topics include the initial assessment and diagnosis of patients with acute and sub-acute knee complaints." The same language exists for Chapter 14 ankle and foot complaints and in Chapter 15 for stress-related conditions. In the very first sentence it says, "This guideline is intended to help occupational physicians

and primary care practitioners manage employed patients with acute stress-related conditions of relatively short duration." Clearly this chapter should not be used as a standard of care for those workers who are losing time due to stress-related conditions beyond a short term.

So, the application of ACOEM to patients with serious chronic conditions, particularly those with multiple injuries that overlap one another, can limit necessary care. And just to consider the difficult medical problems of one of the Voters Injured at Work board members Steven Duncan. Mr. Duncan is a survivor of the 1999 Tosco Oil Refinery explosion where four of his co-workers were killed in an explosion. He survived by leaping off the fractionator tower while on fire landing on the roof of a building after falling some 50 plus feet. He has had 50 surgeries, lost part of one hand, suffered severe facial injuries, broke untold number of bones in his legs, and supports the after effects of severe burns. Today he has also been diagnosed with hetatopical ossification meaning that he has calcium deposits growing in his muscle tissue which may require another surgery. He also has increasing problems with sleep apnea as a consequence of the facial injuries where

his face was depressed by about an inch and a half, and as a result of the sleep apnea, he only gets minimal sleep at night. Now ACOEM says nothing about sleep apnea, care for severe burns, hetatopical ossification, facial fractures, nor does ACOEM discuss the need for whatever support services as might be necessary to manage chronic long-term medical problems.

I'm also told that Mr. Duncan was denied car service now because his treatment is not in ACOEM or the car service is not in ACOEM. He has sleep apnea so I don't know -- I don't know that he should be driving.

But we urge the Division in any case to reconsider its position on the matter. To promulgate such a regulation may endanger the health of injured workers and prevent or delay access to medical treatment that may assist workers with their overall functioning, and by attempting to make it applicable to conditions where it clearly is not by virtue of a regulation you will make the problems worse, increase litigation, and further delay necessary treatment.

On a more technical note in Section 9792.21(c) --

MS. BARRETT: Ms. Sugarman, we're running out of time.

MS. SUGARMAN: Okay. I have a couple more minutes here. Treatment shall not be denied on the sole basis that the condition or injury is not addressed by ACOEM. This is inconsistent with existing section 9792.8 that states that treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Guidelines. So, proposed 9792.21(c) should be changed to reflect the existing rule.

Quickly, we would support the creation of a Medical Evidence Advisory Committee. We suggest that the Medical Director be required to select from a list of physicians who are board certified providers and members in their specialty societies as appropriate and who actively practice in those fields. It also makes sense to have the committee begin work immediately on the list of priority items identified by the RAND report and listed earlier, and finally we suggest -- support the suggestion of the California Labor Federation in its written comments you have to add a physician's clinical judgment in the hierarchy of evidence to allow for medical treatment to proceed where no published empirical evidence exists to address that treatment. This is particularly important for those workers who have serious but rare

complications of diseases and for whom experimental treatment might be recommended. We're supporting the comments of the California Medical Association as well as the California Orthopedics Association, and just -- I want to make sure that the working paper from the RAND that was issued by RAND in November of 2004 is part of the rule-making file.

If you need me to get my copy, I will.

DR. SEARCY: I think we have a copy. Thank you.

MS. SUGARMAN: Okay. Thank you very much.

MS. BARRETT: Sandra Carey.

SANDRA CAREY

MS. BARRETT: If you wouldn't mind going ahead and saying your name correctly and spelling it if you wouldn't mind. Thank you.

MS. CAREY: Yes. My name is Sandra Carey. S-a-n-d-r-a. C-a-r-e-y. I offer testimony today on behalf of the Council of Acupuncture and Oriental Medicine Associations. Thank you for this opportunity to appear before you on the subject of the proposed regs. As we all know these proposed regulations have their genesis in workers' comp reform legislation of 2003/2004. We also know an unintended consequence of that reform legislation was the virtual removal of acupuncture from the workers' comp system, thereby

robbing injured workers and the workers' comp system of this proven successful and cost-effective medicine. Though there are those who would claim otherwise, there is no debate about the efficacy of this medicine and the results that have ensued from its use for injured workers. What does seem to be in debate is how to get this medicine to the patient. And so here we are. The subject of workers' comp reform legislation mandated that the Administrative Director adopt comprehensive medical guidelines or treatment utilization schedules for all modalities utilized within the workers' comp system. The Administrative Director was to accomplish this task by the end of 2004. Clearly we are well beyond that deadline date. The reform legislation further directed that until, and only until, these comprehensive guidelines were developed and adopted that the ACOEM Guidelines would be deferred to and considered presumptively correct for that period. The state contracted with the RAND Corporation, which you've heard many times today, to do an in-depth study of all available medical treatment guidelines including ACOEM to determine completeness and sufficiency. RAND found that ACOEM Guidelines were deficient and inadequate. That they were not comprehensive. That they did not address

acupuncture and others -- and other modalities in a sufficient or comprehensive manner.

They further determined that to develop truly comprehensive medical guidelines is an almost impossible task, given the diversity of several modalities within the workers' comp system. And, indeed, the Administrative Director instructed the Council of Acupuncture and Oriental Medicine Associations to develop peer-reviewed evidence-based treatment guidelines for acupuncture as a specialty guideline, to confer with the RAND corporation for guidance in achieving sufficiency in such guidelines and to submit such guidelines to the Administrative Director by December of 2004.

CAOMA, in partnership with numerous medical experts, did just that. They developed the acupuncture and electroacupuncture evidence-based treatment guidelines December 2004. These guidelines are peer reviewed. They are nationally recognized. They are research, evidence and result based. In fact, they are compliant with the mandates and requirements of the National Institutes of Health, the Academy of Sciences, the Institute of Medicine and National Academy's report on complimentary and alternative medicine therapies in the United States,

and they have been accepted by the National Guidelines Clearing House. There is no question of their veracity, their evidence base, their peer review or their national recognition.

The Acting Administrative Director has not adopted these guidelines after almost two years. Consequently and unfortunately, the results of this inaction are widespread denial of acupuncture for injured workers. And now the Administrative Director has proposed status quo for injured workers, proposed to make the ACOEM Guidelines a permanent and sole treatment guideline structure for this system, all the while knowing these guidelines are not comprehensive and are inadequate and incompetent in treatment for, for, a cost effective treatment for injured workers. She has suggested that conflicting recommendations for various specialty modalities would be confusing to the provider, the employer and the claims adjuster.

I must tell you, if this weren't so astonishing, it would be amusing. Are we saying that we provide only traditional western medicine treatment for injured workers because to provide otherwise is just too confusing? Are we agreeing, as these proposed regulations have suggested, that the only way an injured worker can get the optimum medical procedure

is to enter into a rebuttal process, which we all know is just another term for quicker(phonetic) injury or your pain on hold for the next six months? Are we suggesting that patients do not have the right to effective treatment of a more natural and less invasive sort because it is just too perplexing? That is not only utter nonsense, but it is also in direct contravention of the law. Acupuncture has been an accepted medical protocol in the workers' comp system for almost 20 years, and now it is just too complicated for the folks at Division of Workers' Comp to figure out how to effectively provide it to the patient?

Section 9792.21, the proposed rule making, states: "The ACOEM Guidelines are intended to assist the medical treatment providers by offering an analytical frame work for the evaluation and treatment of injured workers, that they are intended to help those who make medical treatment decisions regarding the care of injured workers understand what treatment has been proven effective in providing the best medical outcomes to the workers."

Now, how do you think the ACOEM Guidelines are going to be able to do all that intending and analyzing and assisting when they do not include all

the modalities that are supposed to be made available to the patient? We do not accept this, and we reject the proposed regulations on the basis of the fact that they are inadequate, deficient and in violation of the word and intent of California statute. We would ask the Administrative Director and the Division of Workers' Compensation to remember that the purpose of the guidelines is to insure that legitimate and proven health care is provided on the basis of results and on a cost effective basis. So, for example, very positive procedures are not repeated, repeatedly utilized when there is no positive outcome for the patient, as has been the case very often with traditional medicine in the workers' comp system. The guideline is a positive result measure, which is the only result measure of relevance, using the different protocols.

The Administrative Director has reportedly made the determination that adoption of these regulations will not eliminate jobs or businesses within California. She has further represented that adoption of these regulations will not have a sufficient adverse economic impact on the private persons or directly affected businesses. I must tell you, there seems to be an avoidance of the obvious in these

representations. While it might not be of sufficient import to the Administrative Director, it is of enormous import to the many practitioners of acupuncture whose practices have all been wiped out. It is of significant import to the private persons or directly affected businesses who are unable to go back to work or resume their businesses because they are unable to receive relief that will alleviate their pain and suffering.

We must respectfully request that the Administrative Director and her staff go back to the drawing board, and hopefully with a more proactive and inclusive approach that has been mandated by the California state legislature. To adopt regulations that defy the intent of the law and systematically eliminate legitimate and lawful medical protocol from this system is not only negligent, but it is irresponsible.

We must remind you of one inarguable fact. Only by comparing all available options can be the most, can the most effective and efficient treatment protocols for each and every condition of ill health and disease be identified. To do less, is to cheat the patient and to fail in your fiduciary responsibility to the public.

Thank you.

MS. BARRETT: Kathleen Creason. Again, if you wouldn't mind spelling your name.

MS. CREASON: Sure.

KATHLEEN S. CREASON

MS. CREASON: Thank you very much. My name is Kathleen Creason, C-r-e-a-s-o-n. I'm Executive Director of the Osteopathic Physicians & Surgeons of California.

As I believe you know, osteopathic physicians are fully licensed physicians in California. They receive medical training equivalent to a medical doctor. They also receive additional training in manual manipulation. And these points are relevant because I think all of this ties into workers' compensation. There are a significant number of osteopathic physicians who participate in the workers' compensation program and, therefore, are very interested in these regulations.

I have submitted written comments, but I would like to highlight three points from them. The first one is OPSC commends the Division of Workers' Compensation for the proposal to establish a Medical Evidence Advisory Committee, Section 9792.23(a)(2). The information that was indicated in the explanation

had reasons for establishing each of the medical areas that were designated in the various positions. And the primary factor is that the ACOEM Guidelines in these specific areas were either inadequate or incomplete. And I'd like to emphasize that osteopathic manipulative treatment would fall under that same category and, therefore, would like to encourage the Division of Workers' Compensation to include an osteopathic physician on that committee.

Second point I'd like to bring up is the issue of evidence-based medicine, and OPSC reiterates the points that were brought up by the California Medical Association. We're very pleased to see the categories A, B and C included, but emphasize very strongly that we feel that category D should be considered as well. It is -- There are a variety of areas that could never be qualified or quantified under criteria that falls under A, B or C, so, therefore, we encourage the Division to consider implementation or consideration of category D as well.

And, finally, a point that our organization has brought up before, but I believe that it bears repeating, is that frequently in the discussions the issue of injuries not included or not discussed by ACOEM has been addressed, but the issue of treatment

not addressed by ACOEM has not been addressed, and I feel that that is a very crucial aspect, because there may be an injury that's addressed, but not all of the treatment modalities have been considered.

Thank you for your consideration.

MS. BARRETT: Thank you very much.

Okay. Steven Schumann. Margaret Gokey.

MARGARET GOKEY

MS. GOKEY: Margaret Gokey, G-o-k-e-y. I am an occupational therapist, in private practice in California for 23 years. I'm also committee chair for the third-party reimbursement for Occupational Therapy Association of California. There are about 9,200 occupational therapists and occupational therapy aides in California.

And I also just want to concur from our first speaker, Marry Foto, and so I really don't want to take up a lot of your time today, but I've submitted written comments, and there are just two things that I'd like to highlight today.

Under the Medical Treatment Utilization Schedule, my own personal experience has been that the delay of treatment under the ACOEM Guidelines has affected patients and their outcome. And, unfortunately, we've had situations where we've had to wait 30 days for

authorization, and that's precious time when someone is injured.

And the other area that I'd like to comment on is the Medical Evidence Evaluation Advisory Committee. And we feel very strongly that occupational therapy is a unique field and contributes to the rehabilitation of industrial injuries. And we really feel that it's important to be able to have an occupational therapist part of the treatment team.

Thank you for your time.

MS. BARRETT: Thank you very much. Richard Bookwalter.

RICHARD BOOKWALTER

MR. BOOKWALTER: Hi. I'm Richard Bookwalter. I'm an occupational therapist and I'm the President of the Occupational Therapy Association of California. And then Margaret said just basically everything that we wanted to say, and Mary earlier, but I will give you my card. And I want concur with their testimony.

Thank you.

MS. BARRETT: Thank you very much.

William Zhao. William Zhao.

UNIDENTIFIED SPEAKER: He spoke earlier.

MS. BARRETT: Z-h-a-o. I'll come back to him.

Jim Fischer. If you wouldn't mind saying and

spelling your name.

JIM FISCHER

MR. FISCHER: Sure. My name is Jim Fischer, F-i-s-c-h-e-r. And I work for a company called Empi.

I am a chronic pain patient myself. I worked in the emergency room at John Muir Medical Center in Walnut Creek. Three years ago I slipped and fell taking a gunshot victim to CAT scan, and I herniated my L5-S1 on both sides, tore my left ACL, ended up in the workers' comp system. And, you know, I'm going to blow my anonymity. I'm in Alcoholics Anonymous. I want to mention that because it's very important to what I'm about to tell you.

I was given an array of medications and they tried to treat me solely with narcotics, opiates. And, frankly, after about 15 months my wife was not very happy with me. I was restless, irritable and discontent.

And I really, I notice that the pharmaceutical companies are here today really knocking on the door, coming down to the microphone complaining. I notice that pharmaceutical companies are here today, they're really complaining a lot about ACOEM. And what this lady said right here is very important. Who's backing ACOEM, who's investing? You know, Smith Kline,

Pfizer. We all know that we can trust the Smith Klines, the Pfizers, the Mercks of the world. That's all relative to the Cox-2 inhibitor fiasco this past year where the, it was proven that there were people on FDA that were actually paid by the pharmaceutical companies. So we can't really trust the studies, or even everything that we read in JAMA.

I want to welcome everybody that's come down here and spoke. The OTs and PTs, they are definitely suffering, the durable medical representatives here, as well as the family practice physicians.

It's been my experience that after 15 months of a lot of medications, that it was a simple TENS unit that's worth about $300 that allowed me to return to work. I went to physical therapy; it helped. But people didn't order a TENS unit for me because, you know, they felt like it wasn't going to be authorized through workers' comp.

I happened to go to work for the company and used myself as a guinea pig, and it worked, and I drive over 200 miles a day today. I have a territory from Brentwood to San Francisco to Oregon, and I drive a little PT Cruiser. And it's because of that TENS unit that I'm able to work today. I wish I'd got that TENS unit some time after my microdiskectomy and before all

the drugs that were introduced and my doctors telling me it's okay, it's okay. You know, I was on -- when I finished and decided to make the choice to go back to work, I was on Lortab, which is like Vicodin, I was on Ambien to help me sleep at night, Elavil for nerve pain, Celebrex and Lexapro, not to mention all the other drugs I was on before that.

So what's frustrating for me is that I'm carrying a message to pain patients in doctors' offices, physical therapy clinics, and they're being denied a simple TENS unit or a muscle stimulator that will help them. They're being denied a traction device that works correctly. Instead, they're authorizing an over-the-door traction device that's a bag full of water. It comes with a free goldfish, by the way.

My point is, you know, I think that we cater to the pharmaceutical companies, we cater to who has the money and, you know, we're not practicing the best medicine possible right now in the State of California.

Thank you.

MS. BARRETT: Okay. We have about ten minutes. I'll call one more person and then we've got -- How about we take the next person and see how it goes. Stephen Kessler with Berkeley Labor and Community

Coalition.

STEPHEN KESSLER

MR. KESSLER: Good morning. Sorry. Good afternoon. I should say that I'm speaking on my own behalf and I'm actually going to give you a narrative of my experience, how it --

MS. BARRETT: I'm sorry, before you go any further, your name is Stephen Kessler?

MR. KESSLER: Yes. S-t-e-p --

MS. BARRETT: K-e-s-s-l-e-r?

MR. KESSLER: Correct. Stephen with a p-h.

MS. BARRETT: Okay.

MR. KESSLER: Anyway, I had the opportunity to speak in this room a couple months ago when the Commission was having hearings, and I spoke from the vantage point of having worked with people who are homeless and, specifically, talked about a study that I did in graduate school, case study, where I established a number of people who became homeless because of occupational injuries.

Relative to today's considerations, I think it should be noted, perhaps it's obvious, but let me, at the risk, say it anyway, most homeless people do not over consume medical benefits or anything else. And if you look at the survey and certain of the research

relative to the RAND study and other studies, they don't have researchers going to homeless shelters, to day labor centers or community clinics where people are disproportionately underserved. So I think that tends to skew the numbers.

I'm glad that I'm able to address the Commission today. My comments are those of an injured worker experiencing long-term chronic disabilities. Briefly, my injuries date back to July of 1987, and I had a stipulated agreement in 1992 with SCIF, the State Compensation Insurance Fund.

Like many other workers who thought they had medical treatment guaranteed by virtue of what was a legally binding contract, I was disabused of that notion at the end of '94 when I was first refused medical care and continued to be so denied. So much for the viability of the contract.

I was denied both physical therapy and a gym membership, as well as subsequent x-rays and MRIs, the latter being the appropriate diagnostic tools my doctors believed had helped to fairly determine the medical necessity for the above therapies and assess how much my body has deteriorated over time. I just got a rude awakening about that deterioration, which I'll go over later. I was also denied all prescribed

medications, had to appeal through the utilization review of the carrier. Eventually I got the medications. And it should be noted that the insurance company's own doctor had recommended annual sessions of physical therapy, a gym membership and medication.

When I said that I was glad that I was able to address the Commission today, I should qualify that statement. I'm furious that I have to be here, but given the events of early last month, I'm glad that I'm here and alive. I had to be taken to the emergency room with what turned out to be a bleeding ulcer. Up until that point, I didn't know that I had an ulcer, let alone one that was bleeding. The doctors concluded that Ibuprofen was not an appropriate substitute for the relief of pain that rigorous physical therapy and regular gym memberships would have provided and would provide.

I'll never forget the look on my daughter's face when she saw me looking like hell with a tube up my nose and down my throat and my stomach to help get rid of the pint and a half of blood that had collected there. I choose not to be reminded of the hospital's inquiry as to my willingness to be an organ donor, as the event suggested. There was a bit of a concern

there. Doctors are clear that the medication caused the bleeding. I don't want to take, have to take medications, and if I do, the bare minimum necessary. By the way, I was also, had been previously been given Vioxx and Celebrex, which are no longer advised.

The monies wasted on utilization review could have been paid for much of my therapy and wouldn't have to be spent reimbursing the hospital for my stay in the ER and subsequent admission as a patient. I'm determined that at minimum, State Compensation Insurance Fund will be reimbursing the hospital, specifically, Alameda County Medical Center, otherwise known as Highland, and not allow SCIF to off load or externalize their costs onto us, the taxpaying public. This is a compensable injury, I've been informed.

These unnecessary costs that threatened my life and caused so much grief for my family are also bad public policy. The State of California can do better and, specifically, the Division of Workers' Compensation.

Let me go on. An exclusive state fund is in part something that should be considered, at least looked at in consideration of the reliance on the mix of State Compensation Insurance Fund with the private carriers. And, unfortunately, SCIF acts like a

private carrier. An exclusive state fund wouldn't be the predatory, act like a predatory company, as my experience has been. I will be, along with the statement, giving you an article by the late Bruce Poyer, who wrote on the topic --

MS. BARRETT: Sir, if you wouldn't mind --

MR. KESSLER: Wrapping it up?

MS. BARRETT: No, not necessarily. But limiting it to the regulations.

MR. KESSLER: Okay. I'm getting -- I'll get -- Yes, I will return to ACOEM Guidelines, as in terms of my case. Relative to the points of the ACOEM Guidelines, I was, got a copy of the letter that was sent to the doctor, the qualified medical examiner who I saw a couple weeks ago, and in this letter they mentioned, among other things, that I'd had knee surgery, when I didn't have knee surgery. They mentioned that it included a medical report, and I didn't see, receive the medical report. They mentioned, or didn't mention non-medical reports which I didn't get, and, of course, have asked for. That would include an investigator's report for a car accident that I had on the way to the physical therapist when my doctor finally decided I could benefit from physical therapy. And I should note

relative to the acute nature of the guidelines, I wasn't even going to start physical therapy until 90 days after my accident.

Also, there was no mention in the letter to the doctor what the nature of the dispute was. So in one paragraph they did quite a bit, or didn't do quite a bit, as it were.

Finally, let me conclude that like a significant number of workers faced with a denial of necessary medical care, my quality of life has been seriously compromised. Like others, I'm faced with pain and discomfort that disrupts my sleep, makes me function at less than optimal levels, undermines my ability to gainfully support myself and my family, and limits my capacity to be productive as a worker and as an engaged citizen. My experience and thousands of workers will reveal the inadequacy of the ACOEM Guidelines as they pertain to chronic conditions of ill health.

I might add on my way home last night, walking on the streets of Berkeley downtown, there are a number of people on the streets, living on the streets, who are in very bad shape. They're not over consuming health care, believe me.

Let me mention a couple of points to conclude.

I've been informed that the guidelines of ASIPP, the American Society of Interventional Pain Physicians, are more appropriate for chronic long-term injuries than the short term 60 to 90 days range of the ACOEM Guidelines, as other people have discussed at length. My experience with occupationally injured workers, I mentioned, I think, sufficiently, and I will, based upon the discussion today, I think I would do well to give you copies of the letter that was sent to my doctor and the response that I gave them.

Thank you.

MS. BARRETT: Okay. About half a minute. Thank you very much.

Okay. We'll be back. We're stopping at this point and we'll be back at 1:15 p.m. Thank you very much.

(LUNCH BREAK)

DR. SEARCY: All right. I think we're going to go ahead and get started, and I think we'll probably be joined by a few more people, but I know a lot of you have come from some distance so we want to respect that and get started. So we're going back on the record, and Stephanie will call the next person up. She also has a couple of comments, but I just want to make one, and that is that several people have asked

if we will -- if they will get a chance to speak, and we will stay until everybody has had their chance. So, there is no time limit as far as we're concerned. We're not going to close it at 3:00 or whatever. However long it takes to hear everybody we plan to stay.

MS. BARRETT: Okay. And just a couple of remarks before I call the next name. The applause between speakers, if you could refrain from doing that, it will be appreciated, and anybody who has a cell phone if you would just check to make sure that it's actually off or on the vibrate mode that would be a good idea. As much as you -- the comments you might want to make while someone else is speaking, please refrain from that. Anything you want to put in writing, you're welcome to do and it will be accepted before the end of the hearing today.

Okay. Steve Schumann.

STEVEN SCHUMANN, M.D.

MR. SCHUMANN: Good afternoon. Thank you for your time. My name is Steven Schumann. I'm here today on behalf of two organizations. American College of Occupational and Environmental Medicine, ACOEM. Of course the recognized author of the ACOEM Guidelines. As well as the -- its regional, western

regional component, Western Occupational and Environmental Medical Association. We appreciate the opportunity to comment. We appreciate the Division's efforts to implement the work comp reforms of 2003/2004. The California reforms demonstrate that the use of evidence-based guidelines can help workers receive appropriate care in a timely and cost-effective manner.

Briefly, we want to mention several ways that ACOEM is making its Practice Guidelines more easily and effectively used. Number one, ACOEM publishes "APG Insights", a newsletter that offers supplemental material to the guidelines. It includes updates from medical literature, current analyses, and further explanations designed to help users understand the guidelines and better use them in their practices.

Number 2, ACOEM has also developed a Utilization Management Knowledgebase (UMK). This easy-to-use electronic tool helps providers, case-managers, and reviewers make appropriate care management decisions communicating clearly about the Guidelines.

Number 3, ACOEM is also moving forward with a regular and predictable updating process that includes review of new therapies and literature and expansion on the guidelines where appropriate. This will be a

progressive refinement of the Second Edition, with a rolling set of guideline updates to be issued over a three-year period. The first updates will be published later this year or in early 2007 and will address the elbow and the spine.

The updating process is the work of two bodies. ACOEM's Evidence-Based Practice Committee, with its sub -- body-part subpanels acquires and evaluates evidence, brings forth recommendations to update the guidelines. This group includes more than 50 physicians from appropriate specialty areas, as well as other health care professionals.

A second committee composed of four ACOEM members and three members from other major national specialty associations is charged with watchdogging the evidence-based methodology and ensuring a collaborative effort among specialties, and that all topical reviews adhere to the fundamental evidence-based principles.

ACOEM has listened carefully to comments raised by various stakeholders in California, and we are committed to addressing the issues in our update process.

We invite input from those who have concerns that the recommendations found in the Second Edition are

incorrect or not in keeping with the conclusions of current, high-grade medical literature. Please send us your comments along with citations, and we'll certainly evaluate those.

The other comment I would make, as an aside here, is I think a number of the issues that are raised, I think one needs to distinguish between the content of the guidelines and the implementation of the guidelines, and I think we all recognize that there have been some challenges in both areas, but ACOEM is committed to currency of the guidelines, having those be effective in the workplace, and there are many of us in practice who see patients on a daily basis using the ACOEM Guidelines, find them to be effective. We think that many of our patients appreciate what we do. The eight hours I spent in the clinic yesterday with my patients, I think most folks would feel they're getting good quality care, and we attempt to use the guidelines as we practice medicine on a daily basis.

In addition, WOEMA, ACOEM's regional component society, would like to recommend two additional seats be designated on the Treatment Guidelines Advisory Committee. These actually have already been mentioned but I'll repeat to say that one seat would be occupied by an expert on clinical research of no particular

affiliation, who would help guide the committee's discussions regarding evidence hierarchies, research reports, and the relative scientific merit of various sets of guidelines.

A second seat would be occupied we request by a family physician. Family practitioners serve as treating, primary treating physicians and assist in a greater number than perhaps any other specialty. We believe that their input would be valuable as well.

Thank you for this listening to my comments.

MS. BARRETT: Thank you very much. L-i-u, Liu. I think the name is R-u-i, Q-u-i-o-n-g, Liu. In Oakland, from Oakland. Okay.

Deborah Hutchings. Is Deborah Hutchings here?

UNIDENTIFIED SPEAKER: Is it Harris?

MS. BARRETT: It's H-u-t-c-h-i-n-g-s, Deborah. In Antioch.

Robert Weinmann.

ROBERT L. WEINMANN, M.D.

MS. BARRETT: Be sure to say and spell your name. Thank you very much.

MR. WEINMANN: My name is Robert L. Weinmann, M.D. I'm a physician neurology, and I'm President of the Union of American Physicians and Dentists, which is a local of the American Federation of State,

County, and Municipal Employees ALF/CIO, one point four million members.

I have a presentation. I'll skip through it because many points have been made. The ACOEM Guidelines in my opinion should not be adopted. They should not be used at least any further than they're being used now. Because the concept in law that they are presumptively correct is actually incorrect in medicine and science. As a physician some things are right about the ACOEM Guidelines, many things. Many things are also wrong. But by law all of it is correct.

We should probably have the ACOEM Guidelines rescinded all together. We should also try to reconstrue them so that they make more sense and come -- can come closer to being deserving of being called presumptively correct. I testified on SB899 right after Senator Poochigian, and one of the items that I remember about Senator Poochigian when pain was discussed, was he said how does anyone know -- how does a doctor judge that a patient is in pain. He said the doctor examines the patient, maybe he palpates something or other, and the patient winces with ostensible pain. The word he used was winces. He said that's how a doctor knows somebody is in pain,

and everybody laughed because everybody knows wincing doesn't necessarily mean pain. Wincing can be fakery; wincing can be anything; wincing can be anything but what it really is, namely an expression of pain. When I saw the legislators listening to that dribble, I understood that we were really up against something. Now Senator Poochigian is a decent man. He's a good guy, and I have attended a fundraiser or two of his. All the same he was dead wrong in his dismissal of patient's pain, and the ACOEM Guidelines with reference to anything chronic and especially chronic pain are either incomplete or dead wrong.

In Labor Code 4610 we are told that the utilization review doctor should have knowledge of the subject about which he is providing utilization review. That he should be up-to-date in the state of the art of the treatment modality that is being requested. Unfortunately, I have seen on more than one occasion a remark like this by a utilization reviewer. Although I am of the same specialty as such as such doctor, I have never used this particular modality of treatment, do not know anybody who does, and have no familiarity with it. Therefore, it is rejected as incompatible with the ACOEM Guidelines. Actually, it's a statement that is incompatible with

Labor Code 4610, the appropriate section. Because the doctor who did the utilization review was required by that Labor Code to be up-to-date and to know what he was talking about, but he doesn't have to, and the insurance company likes it just fine when he rejects the treatment anyway.

In one case that I was personally associated with I recommended a type of treatment and it was reviewed by a doctor with a Connecticut license but no California license, and although he expressed a lack of familiarity with the treatment that I wanted to do, he nonetheless recommended its rejection but not directly to me, not directly to the patient. No, sir. The rejection notice went to a Dallas, Texas, utilization review company, thence to me. So, here we have a California doctor examines a patient, interviews a patient, the records are sent to a doctor in Connecticut without a California license, who determines that the treatment shouldn't be done or isn't necessary, who then tells a utilization review company in Dallas, Texas, that that is his opinion, and the Dallas, Texas, company communicates that and the patient is denied. Of course, in my practice and given my personality I just love it. I submitted it for expedited hearing, recommended that that be done,

and basically I find out that with most of the utilization reviews that seem unfounded, expedited hearing is the next step. The lawyers don't necessarily like that. It takes a lot of time on both sides, but it usually works. You also know and have heard that doctors according to the Labor Code are supposed to be licensed in California if they are going to influence care, and the way it's written in the Labor Code, it says that the doctors who may modify treatment, delay treatment, deny treatment, even approve it are supposed to be licensed in California.

MS. BARRETT: Doctor Weinmann, could you stay within the proposed regulations please.

MR. WEINMANN: Okay. That point having been made I can just skip it. I have submitted to you a letter from Barry Eisenberg from the American College of Occupational Medicine, and it expresses his opinion to Senator Barry -- to Senator Alarcon that the ACOE and utilization guidelines are being used incorrectly. Anybody who wants a copy of that letter in this room can have it, because I have some extra copies. But it is important that you notice that the executive of ACOEM while thanking the Legislature for its confidence in his organization at the same time points

out that his guidelines are being misused. That should stop, and I believe you have the power to put a stop to it. The other doctor who is with me today who is the president elect of the Union of American Physicians and Dentists Stewart Bussey, M.D.,J.D., told me that he used to do workers' comp, but as the utilization review has become more and more complicated, as the guidelines have become more and more oppressive, he has found it best just not to do workers' comp at all. On the other hand, he works in this building in social security, and he finds that what is happening is that more and more people are trying to get reimbursed through social security because they are being denied at the workers' comp level. This is a type of cost shifting also. Not exactly within your purview, but something about which you should be concerned.

I think that these points are some of the points that I need to make. I don't think I have to go through the entire testimony.

I would point out in closing that the American Federation of State, County, and Municipal Employees, one point four million members, had a meeting in Chicago last week, and thought that this issue of utilization review by doctors without licenses in the

states in which their opinions are given, should be stopped, and adopted a resolution with no out -- with no negative votes, and I want you to think of that. That means there was about five thousand delegates in the room and no one objected. So, we now have a labor union that has adopted as a nation-wide plank that it is wrong to allow utilization review to be done by doctors who do not have licenses to practice medicine in that state.

MS. BARRETT: Doctor Weinmann, your time is almost up.

MR. WEINMANN: Okay. As a private practitioner my worry about that is, once I have prescribed treatment that has been denied or delayed, I remain the treating doctor subject to malpractice. The doctor in Connecticut has a free ride, and all he has to say is no. Thank you.

MS. BARRETT: If you can refrain from the clapping between, it will expedite the process.

Stewart Bussey. Dr._Bussey please.

MR. WEINMANN: Not here. I included his comments.

MS. BARRETT: Okay. Thank you. Harry Purcell.

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HARRY PURCELL

MR. PURCELL: Good afternoon. My name is Harry Purcell. H-a-r-r-y. P-u-r-c-e-l-l. I represent a company named Emsi, Electrostim Medical Services, Inc. We are based out of Tampa, Florida, but do business nationally including California. The reason I'm here today is to address specifically the ACOEM Guidelines and to reiterate the fact that, as many of those present here today have said, I think does not adequately address chronic pain or chronic care of pain. It defines chronic pain. It defines acute and sub-acute pain very well. I don't think that there are adequate guidelines to deal with chronic pain solutions. And many of the algorithms that are available for caregivers, again specifically deal with acute or sub-acute. I think if you were to go back over the record you would find that approximately 80 percent of the people here today have at some point mentioned the issue of chronic treatment for patients, and I think that's something that we need to address.

MS. BARRETT: Thank you.

MR. PURCELL: Thank you.

MS. BARRETT: Okay. Shahidal Marie Musawwir.

UNIDENTIFIED SPEAKER: She's not here.

MS. BARRETT: Not here. Would you let us know if

she comes back. Carl Brakensiek.

CARLYLE R. BRAKENSIEK

MR. BRAKENSIEK: Thank you and good afternoon. It's been a long day. I'll try not to take a lot of your time.

MS. BARRETT: Would you - I'm sorry. Would you mind saying --

MR. BRAKENSIEK: Carlyle Brakensiek representing the California Society of Industrial Medicine and Surgery and California Society of Physical Medicine and Rehabilitation, U.S. Healthworks, and VQ OrthoCare.

To begin with, you have heard a lot of testimony this morning, particularly from frustrated injured workers, about how they have been denied care or harassed or delayed in everything, and I can assure you that was just not orchestrated testimony. I represent over a thousand doctors, and I get calls daily from physicians who convey the same message to me; that they are having difficulty trying to get necessary treatment to their patients because of the delays, the denials, etc., that come as a result of the misapplication of the ACOEM Guidelines. It's seriously a problem. I admire your efforts. Frankly I think the Legislature gave you an impossible task as

far as putting together a set of treatment guidelines for long-term use. I recall a conversation I had with one of the physicians who is deeply involved in the preparation of the ACOEM Guidelines. Shortly after they were published they held a meeting in Toronto. I went to the meeting, talked with the physician, and I asked him, I said, "How come your guidelines do not apply to chronic injuries?" And he said, well, that's true they don't apply to chronic injuries, and the reason they don't is because we searched and looked around and we couldn't find any scientifically-based, evidence-based guidelines for chronic injuries that was appropriate. So, that's why they were intentionally designed to cover only acute and sub-acute injuries. I think ACOEM has attempted to revisit this issue recently, a little revision of history, but at least for someone who is directly involved in the promulgation of the Second Edition I do not think there is any effort put in to apply to chronic injuries.

It's also been brought out today that when RAND reviewed various guidelines that are out there, they -- I was at that meeting too down in Santa Monica in which they refer to the ACOEM Guidelines as mediocre. That's the word they used. These are mediocre

guidelines. And cutting to the chase, we're really talking about what guidelines will have a presumption of correctiveness. Because there are hundreds of guidelines out there that can all be used for utilization review purposes, but what we're really talking about today is which guideline or guidelines is going to have a presumption of correctness that will basically, unless overcome, will trump other guidelines that are being used.

There have been many witnesses: Mr. McFarren from CAAA, COA/CMA. We've all expressed many, many concerns about adopting the ACOEM Guidelines as being presumptively correct. Under the statute, as you know, your guidelines must be evidence based, scientifically based, nationally recognized and peer reviewed. In my opinion, the ACOEM Guidelines fail at least two of those tests. They are not all scientifically based, and they are not all peer reviewed, and so I think frankly, as a matter of law, you cannot adopt the ACOEM Guidelines across the board as the A.D.'s guidelines because they fail to meet the standard established by the Legislature. Now true, as I said a minute ago, this is an impossible task for you. I think the Legislature gave you this task, and you cannot legally comply with it, and perhaps the

proper approach would be for the administration to support puritive legislation so that, when you do promulgate your guidelines, you will have something that will comply with what the statute reads.

The Legislature adopted the ACOEM Guidelines as interim guidelines. That frankly it was pig in a poke. At the time they were adopted no one knew what the ACOEM Guidelines were. They had not been published as of the day that the Governor signed the bill adopting them as interim guidelines, and you can't go through this regulatory process and turn -- turn that sow's ear into a silk purse. It just will not work. It is a -- ACOEM is abused now. We've heard many stories about that, and certainly I would urge you not to perpetuate the abuses by elevating these guidelines to a presumption of correctness when it is legally impossible.

Thank you.

MS. BARRETT: Thank you. Thank you for refraining. Is Steve Cattolica here?

STEVE CATTOLICA

MR. CATTOLICA: Good Afternoon. My name is Steve Cattolica. It's spelled C-a-t-t-o-l-i-c-a. And I will say this, that you did much better than the first time I tried. I want to thank you folks for the

opportunity to contribute. I represent the California Society of Industrial Medicine and Surgery as Carl does, the California Society of Physical Medicine and Rehab and the U.S. HealthWorks. Our fundamental point of view regarding the utilization schedule conforms in large part with the findings of the RAND Institute and provided to the Commission on Health and Safety in Workers' Compensation. They found, of course, that the -- they found fundamental flaws in every treatment guideline including ACOEM. And, in fact, they found no set of guidelines that, taken in their totality, matched the Labor Code requirement of being evidence based and scientific based. They also found that no set of guidelines including ACOEM were comprehensive enough; that is, addressed enough of the occupational injuries so as to stand alone without requiring additional guidelines by which to compare and do proper utilization review. So, the Division in adopting the ACOEM Guidelines alone at this time, while expeditious, leaves wide gaps in the coverage of common occupational injuries and illnesses. The exclusion of consensus as a level of evidence leads the Division to acknowledge that the fact that this gap widens because virtually every guideline available, including a number within ACOEM, are based

upon no better than D level or consensus evidence. Examples of such gaps are in psychiatry, as well as internal medicine in which ACOEM is completely silent. Taking advantage of these obvious gaps carriers are denying much treatment as not supported by ACOEM. Not withstanding the proposed regulation against such utilization review practices, we maintain that it would be better to provide a well-respected and comprehensive tool for the payers to work from than to leave mental health or the treatment of internal complaints to protracted deliberations that are sure to be adverse -- adverse effect to the injured worker as well as increased costs.

We've got a couple of suggestions specific to the proposed regulations. The first is a structural suggestion. Clearly from the RAND study and your own deliberations or your own respect for the contributions of the coming committee that will be formed to use ACOEM throughout the article in such specific ways will cause you folks to have to rewrite the whole of the article each and every time a new guideline is added. So, we suggest that 9792.21 be shortened to become simply a list of those guidelines that are comprising the schedule. That takes point 22 to pick up the slack of the rest of what is now point

21 and renumber the rest of the article. And you'll see that in our written comments. We believe that that will build in some flexibility for you folks going forward under the presumption, of course, that ACOEM, as we've maintained and you've heard before, is not adequate in its entirety and more needs to be done.

We have two main points to make with respect to the actual level of evidence. The first is bestowing presumption of correctness when guidelines are not based on scientific evidence. Draw your attention to 9792.21(b). It's been quoted before, but our point is that where it says in part it's supposed to help those who make decisions regarding medical treatment of injured workers understand what treatment has been proven effective in providing the best medical outcomes, we note that the consensus is not accepted evidence, and guidelines based on consensus therefore cannot be proof, and we do not -- they do not deserve a presumption of correctness. We suggested to replace the word proof with "found" or perhaps ACOEM's own words "most likely." In recognition of this conclusion, plus the fact that ACOEM Guidelines recommendations are in many cases actually consensus based, and thus should be disallowed by Labor Code

4604.5(b) or excluded by the very definition of evidence found within the article.

In each applicable chapter of the ACOEM Guidelines there's a table that provides recommended optional and not recommended clinical measures. Of the recommended clinical measures in all those tables there are included 43 percent based solely on D level evidence. In our written comments there are exhibits that compile that data and also provide the source of that data. As the Division is aware, D level evidence is defined by ACOEM as panel interpretation or consensus of evidence not meeting including criteria for research-based evidence. Chapter 13, which is the knee section, knee complaints, provide an example. I won't go through the details of that table that I've just handed to you, but again it's the table of recommendations optional and not recommended clinical measures from the chapter on knee complaints. It's ironic, we believe, to find that 43.7 percent of the recommended clinical measures throughout the ACOEM Guidelines are based not on hard evidence, not scientific evidence, but on the panel's consensus. We believe that irony is compounded by the fact that approximately 61 percent of the clinical measures considered not recommended by ACOEM are also based on

D level evidence. Thus, we find that since consensus is necessary at both ends of the recommendation spectrum, there's no factual basis for a presumption of correctness in either case. Placing a presumption of correctness upon consensus guidelines renders both the schedule and the utilization review process confusing, ambiguous, and contrary to law.

The Division within its Medical Treatment Schedule proposes to adopt guidelines in which 48.7 percent of the clinical measures considered are disallowed by the enabling statute. We also recognize that in adopting the criteria for future guideline consideration that without radical and complete updating from ACOEM the ACOEM Guidelines themselves would be disqualified in much of its entirety.

Now our comments are not meant to denigrate ACOEM or the Division's work. As Carl said you've got a herculean task that may in fact be impossible to accomplish, but rather we want to simply point out the conflict between proposed medical treatment schedule and a presumption of correctness. Thus, we recommend that in no case should a presumption of correctness be in effect for any recommended clinical measure or any treatment guideline or treatment modality whose efficacy or lack of efficacy is based upon D level or

consensus evidence.

Our second point addresses the application of any guideline outside of its original intent, specifically 9792.22(a), wherein you allow the ACOEM Guidelines to be available to evaluate acute and chronic medical conditions. It's been stated before, but I want to draw your attention once more to the point in Chapter 12 under low back complaints on page 287 where in fact those low back recommendations are specifically aimed at conditions less than three months of duration. The statement is succinct and unequivocal. It clearly means that all the ACOEM Guideline recommendations for treatment of low back complaints are applicable to symptoms of no less than three months. There's no other interpretation possible.

We understand that there are newsletters and publications that have been developed since the original publication of the second edition that attempt to bridge the original intent and make them available to chronic injuries, but we would suggest that those separate documents, if they were to be incorporated into the schedule through these regulations, because they, those advisories themselves are not scientific based, they could not be considered.

So, we're left with two suggestions. The first is that the presumption of correctness should not exist unless a specific medical treatment guideline is directly applicable to the injured worker's injury and condition. Second, that the presumption of correctness does not exist for any medical treatment guideline or specific recommended clinical measure that's based on evidence other than the three levels of evidence defined in this section, meaning the article that you're considering.

MS. BARRETT: You have about half a minute left.

MR. CATTOLICA: I'm sorry?

MS. BARRETT: You have about half a minute left.

MR. CATTOLICA: That's good.

Barry Eisenberg in his letter to Senator Alarcon made a comment with respect to the applicability. He said, and I quote, that "when a physician's request does not meet guidelines, it does not automatically mean that the request is inappropriate." So, in effect, Mr. Eisenberg was making no presumption of correctness with respect to the guidelines and their application to chronic injuries. And the corollary to Mr._Eisenberg's last statement is also true that, notwithstanding the Chatham decision, which is on appeal, when an ongoing course of treatment, such as

for a chronic condition, is compared to the guidelines and found not to meet them, it cannot automatically mean that the treatment is inappropriate.

This treatment schedule is chronically late. Adopting ACOEM Guidelines alone is problematic at best. We applaud the formation of an adequately staffed advisory committee, but the group will take months to take effect, to be of effect. Based on the proposed guidelines, injured workers and their physicians will continue to be held hostage to guidelines that are clearly inadequate for the totality of the job. The Division can quickly remedy this situation by denying the presumption of correctness to consensus guidelines applied prospectively or retrospectively, or applied to conditions acute or chronic to which they were not originally intended. By doing so, you'll engender a timely dialogue between professionals in order to determine the best treatment available.

Thank you very much.

MS. BARRETT: Thank you very much. Did Liu come back, L-i-u? Is Deborah Hutchins here? Okay. Kristine Shultz.

Would you mind saying and spelling your name, please?

KRISTINE SHULTZ

MS. SHULTZ: Sure. Kristine Shultz, representing the California Chiropractic Association, and it's K-r-i-s-t-i-n-e, S-h-u-l-t-z. Thank you for the opportunity to talk today about the proposed regulations before us.

The first point I want to make is the CCA is opposed to the adoption of these guidelines for the utilization scheduled for chiropractic care. We have some substantial concerns that were raised by the RAND study, and in your own Statement of Reasons the DWC acknowledged the fact that they're severely lacking when it comes to chiropractic care. It may not be valid and not comprehensive.

Our concern is that in the Statement of Reasons you mention that you can't do anything about it because there's no other guidelines that are apparently better. But we feel that you can do something. Adopt interim guidelines that would be appropriate for areas where the RAND study has identified that the ACOEM Guidelines are deficient. For those areas a trial of chiropractic care should be allowed in four to six visits. And if there's functional improvement, allow additional care. We think that this is a reasonable approach, an approach

that would get people the care they need, especially considering there's already a 24-visit cap on chiropractic care.

And the second point that we have is we recommend an amendment that would require that the three members of the advisory committee appointed at the discretion of the Medical Director and the three additional members who serve as content experts would not have ties to the workers' compensation industry. We are concerned that the purpose of the committee is to evaluate guidelines and to look at the scientific evidence and considerations of cost implications. Really, this is not appropriate for this type of review. We think that that should be forbidden specifically in the regulations.

Thirdly, we understand, you know, California Medical Association would like to see more physicians on the committee, on the advisory committee, but we have concerns about it being overly focused towards allopathic medicine. Right now, if you look, eight of the ten positions could be -- are eligible to be allopathic doctors, medical doctors, and only two would be complimentary alternative type providers. The concern that we have is that the guidelines that are reviewed in the, might be very tainted towards

that type of an approach. Medical doctors don't have training in chiropractor care. They don't have, many of them don't have experience with it. And that was shown in the RAND report where there was a lot of conflict about what is good practice of medicine. And in those areas of consensus where this looks like this committee will be focused, it's important to have a, a very fair perspective on these types of therapies. We think to solve this problem, have the three additional members be actually public members instead of medical doctors. And also, of course, not tied to the industry in any way.

Lastly, the final issue that we had identified is that although randomized control studies are designated the highest level of evidence, we think that the meta-analyses of randomized control studies should be the highest level of evidence. And the reason why is because benefit analysis is a review of those randomized control studies that, that take it through a process of throwing out the studies that aren't appropriate and aren't scientifically rigid. So we think it's important that those be really the highest level of evidence and be given the greatest weight.

Thank you so much for the opportunity to testify

today and questions. Thank you.

MS. BARRETT: Thank you. Rona Ma?

Please say and spell your name.

RONA MA

MS. MA: My name is Rona, R-o-n-a, last name is M-a, Ma.

Thank you very much for give me this opportunity to stand here. I am the President of the United California Practitioners of Chinese Medicine. That is we have more than 400 licensed acupuncturists practicing in the Bay Area. So I think we have 10,000 in California, right now.

You heard a lot about acupuncture have been treated, you know, after the guideline. So I don't want to repeat that. We have a lot of doctors over there, also represent them, and also I have the signatures here I will hand to you.

So I think probably I tell you one, you know, from my own experience, let you know what we have been treated. Before the reform, I have probably more than 50 injured worker that would be see each year, and the 95 percent has to be referred by a medical doctor. After the reform last year, I only saw 11, and all the 11 has been denied. That mean I see zero patient because of ACOEM Guideline. And this year I have so,

I got four referral from the medical doctor. The reason is that it doesn't matter, the guideline will be denied. So that is a waste their time, waste my time and let the patient getting hurt. So this -- but fortunately, the four this year I saw one patient after I, you know, make the copy of the, you know, the CAOMA publish the acupuncture evidence-based, the guideline to them, so why it has been, so I see them for six visits. And then some of them is the injured worker I saw before, the flare-up. But there has been denied, even though the work on them has been denied because of guideline. And one of my patient is so painful and she have no choice. She pays of her own pocket to pay to see me.

See their, the pain, my heart is broken. So that is I give the treatment for free. I can give one for free, I can give ten for free, I cannot give fifty for free, because the injured worker should be taken care of by the work comp system.

So I'm standing here, you know, I just wanted -- the policy maker and you, you know, give the -- I think I can see the door is shut, shut down because I have 11, 11 denied. And I want, you know, give acupuncture or other treatment available to all the injured worker in California.

Thank you.

MS. BARRETT: All right. Again, if we could refrain from the clapping, that would be beneficial.

Rosie Zamora. Rosie Zamora.

MS. ZAMORA: I'm trying to get my cane out.

MS. BARRETT: Okay. That's okay.

ROSIE ZAMORA

MS. ZAMORA: My name is Rosie Zamora, Z-a-m-o-r-a. I'm here as a patient that has been denied, and ACOEM has sent me a letter stating that I was denied acupuncture treatments.

I had an accident August_10 of 2005, and I had gone to the doctor that the company that I work for sent me to. And the doctor -- they said, okay, we're going to try all these treatments. And they gave me cortisone shots and so forth. They have not worked. They're very painful and they have not worked. The doctor that they sent me to recommended acupuncture, if I was willing.

You have to excuse me, I'm very -- I've been very stressed recently from the job and so forth.

I went to the acupuncturist and I had the first session of treatments, where after a year of shots and all the other treatments nothing worked. Within one session I was back to work. I was only off for six

weeks because I worked through the pain and going through the treatments that they gave me. And now I'm having problems at work with the, with my supervisor and harassment.

Again, like I say, ACOEM has sent me a letter denying my treatments. How they can do this, I don't understand, because after one session of treatments I had gone back to work, and I'm doing my job. And I thank God that my, the primary doctor there asked me if I was willing to do this, and I thank God again for the person that's given me the treatments.

Like I say, the stress -- I was at the hospital the other morning till 4 a.m. because of all this going on. But I just want to say that the guidelines need a little tweak, a little something else in there stating --

(At this point Ms. Overpeck changed the tape in the recorder.)

MS. ZAMORA: Yeah. They need to put in other treatments, because, like I say, I had never been to an acupuncturist. I had never had any of this. And now I'm, I'm, I'm able to work. And, yet, that's causing problems through the job system, you know. Workman's comp, as far as, as I see, it's -- we're just going around and round in circles. There needs

to be guidelines to provide for people like myself who have had nothing but pain in the last year. And I, I wrote myself notes, and I think they went around in circles, too.

But I just wanted to say that if the guidelines could be worked on, other things added, it would help people like myself, would be good.

Thank you.

MS. BARRETT: Thank you very much.

Debra Harris.

DEBRA HARRIS

MS. HARRIS: Hi. My name is Debra Harris, H-a-r-r-i-s.

I was injured in August of 1996, and my doctor had to fight the insurance company to allow me to see a surgeon. Finally in July of 1997, almost a year later, I was able to see the surgeon, and because it took so long, he had to fuse my cervical spine 2 through 7. I also have bilateral drop foot, bilateral carpal tunnel. I have a syrinx in my thoracic spine and disks out in my lumbar spine. I had severe headaches daily which caused me to vomit daily, and I have really bad nerve pain.

My doctor recommended acupuncture, and thank God it has worked. But the doctor who makes the decision

for the insurance company said that it was only helping with the pain and that he recommended that I try aerobics instead.

My surgeon has been asking the insurance company since last September if I could see a surgeon in San Francisco to work on the syrinx that I have because it's been affecting my legs and I've been falling, but the insurance company hasn't answered him at all. And so in June I had to have brain surgery because I fell, and I have a subdural hematoma, and thank God that's been taken care of, too. But there again, the insurance company doesn't want to have anything to do with that.

I don't understand why the fact that I lost my life as I knew it in 1996 isn't enough. I have MRIs, x-rays, EMGs, surgeon reports, et cetera. Why am I not going to have these taken care of for the rest of my life? Why do I have to have life in torment from ACOEM Guidelines, as well as constant pain?

I facilitate a chronic pain group, and members who have had their case settled for years are having problems obtaining care. I believe right now that these ACOEM Guidelines and this whole system needs help. And I do have time on my hands, so if you need help, I'm available.

Thank you.

MS. BARRETT: Thank you. Richard Esquivel.

MR. ESQUIVEL: I prepared some statements just to submit to all of you. Can I give them to you now or after?

DR. SEARCY: No. It's fine.

MS. BARRETT: If you wouldn't mind saying and spelling your name when you get back.

MS. ESQUIVEL: Sure. Okay. Please take one of each. I'm going, I'm going over this one. This is for your reference. I prepared two statements, two different statements for each of you.

MS. BARRETT: Thank you.

MS. ESQUIVEL: Sure.

RICHARD ESQUIVEL

MR. ESQUIVEL: My name is Richard Esquivel, that's spelled E-s-q-u-i-v-e-l. I'm a licensed acupuncturist in San Jose. And I'm normally a very calm and level-headed person, but today I'm, I'm furious about many things. I've been contemplating this while I've been listening to other people.

I think I'm most furious about how little has been done in solving these problems, these issues which have been identified a long, long time ago, over two years ago. They were recognized by, by the A.D.'s

office, at public hearings, they were recognized by RAND and CHSWC, Commission on Health and Safety and Workers' Compensation. And RAND and CHSWC made various recommendations and suggestions on what could be done to solve some of these problems. And now, almost two years later, after the date by which the A.D.'s office was mandated to come up with the utilization schedule, we're being told that the, the A.D.'s office has decided to keep the ACOEM Guidelines in place as is, and has decided to explicitly apply them to all chronic conditions, as well as acute conditions which they were a failure at addressing.

Am I speaking too loudly?

UNIDENTIFIED SPEAKER: You're too close.

MR. ESQUIVEL: Too close? Okay. I'm sorry.

The ACOEM Guidelines have, had been problematic in addressing acute, subacute conditions, let alone chronic conditions, which it has failed miserably at.

And I'm also furious at the reasons which I read in your document for this decision. And I'm also furious that it's taken this much time to come up with, with basically nothing.

Let me tell you a little bit about my practice. I have a private practice that I see injured workers at in San Jose, but I also work at the Alliance for

Occupational Medicine facility in Santa Clara, where I supply acupuncture services to the injured workers there. It's, it's an occupational medicine facility similar to U.S. HealthWorks, that is selected, chosen by various employers and companies to serve as the facility to provide treatment to their employees when they get injured. So it's an employer-selected physician facility. These companies entrust these occupational medicine facilities to provide appropriate care to their injured workers so that they can get back to work. We face the same problems there as I do in my private clinic in trying to get authorization for treatment for these workers, some of which you've heard from today.

I'm also the, one of the editors of the Acupuncture and Electroacupuncture: Evidence-Based Treatment Guidelines that you've heard about, and we spent a lot of time, put a lot of work into the development of the guidelines when we were requested to do so by the A.D.'s office, and also we made sure that we met all the criteria that RAND put forth when they decided to solicit treatment guidelines on the various specialties. We made sure we addressed every criteria that, that they were using as the selection, the selection criteria for the, that they used prior

to evaluating the guidelines. And, and now we're being told that the specialty guidelines will not be adopted, will not be part of the utilization treatment schedule because, for the following reasons -- These quotes come up numerous times in the, in the 50-page document of the initial reasons of, initial reasons of, for adopting the, the utilization schedule. No mechanism has been identified for merging the contradictory recommendations in the guidelines. Conflicting recommendations will be confusing to the provider, employer or claims administrator. And adoption of other guidelines will affect the presumption of correctness on the issue of extent and scope of medical treatment of the ACOEM Guidelines.

Well, this was the task that the A.D.'s office was charged with. I agree this was a very difficult task, but -- it may be impossible, but to take two years, almost two years after the deadline so that -- actually, the A.D.'s office had more than two years because the deadline was probably six months after the time that the legislation was passed, to come out now and say that we're going to keep the ACOEM Guidelines after knowing of all the problems that injured workers have been having in the system. The injured workers testified at the hearing at the end of 2004 at the

CHSWC hearing and the A.D.'s office hearing, it was a different group of injured workers, but they were all complaining about the same thing. And physicians. It wasn't just the injured workers, and it's not just injured workers today, it's physicians in the system that are complaining about the system. So to read now and to hear from the A.D.'s office that it's, no mechanism has been identified for merging the contradictory recommendations sounds to me like the A.D.'s office is sending the public the following message: It's too much trouble to address the problems in the workers' compensation system. It's too much trouble to address the weaknesses and deficiencies of the ACOEM Guidelines and the inappropriate application of the Guidelines. And, essentially, it's too much trouble to develop the utilization schedule that is fair, reasonable and of service to injured workers. Instead, it appears that the A.D.'s office has chosen to make life easier for itself rather than the injured workers of California, which it serves.

I don't even understand the reasoning that the adoption of the other guidelines will affect the presumption of correctness on the issue, extent and scope of medical treatment of the ACOEM Guidelines.

That sounds to me like fuzzy logic, because the utilization schedule was intended to replace the temporary use application of the ACOEM Guidelines in the regulation of treatment of injured workers.

MS. BARRETT: You have about half a minute left.

MR. ESQUIVEL: So either the -- How could the, how could the legislative intent be to afford the presumption of correctness of the ACOEM Guidelines after the Medical Treatment Utilization Schedule is adopted? Obviously, it wouldn't be reasonable, so -- since this would prevent the A.D.'s office from adopting any treatment schedule that's not consistent with ACOEM. So -- and that's, and that is the, is the, seems to be the reason for the adoption of ACOEM Guidelines, that everything else is inconsistent with ACOEM, so we're going to stick with ACOEM. It just, it doesn't make any sense.

I'd like to address a couple of other issues.

MS. BARRETT: Unfortunately, your time has run out.

MR. ESQUIVEL: Can I have 30 more seconds?

DR. SEARCY: That's fine. And then we have your written, so try and bring it to a closure, if you would.

MR. ESQUIVEL: Okay. I'm going to address two

issues in 15 seconds.

One, the chronic conditions in ACOEM Guidelines, chronic recommendations in ACOEM Guidelines. Most, as most the people testified today, most of the recommendations, Chapters 8 through 14, which address treatment of all the body regions, is intended for acute and subacute conditions only. The chapter that does address chronic pain is in Chapter 6. And this is what Chapter 6 says about chronic pain: Typically the chronic pain patient cannot be treated by the interventions that are appropriate for acute pain. This is a direct quote on page 108. Research suggests that multidisciplinary care is beneficial for most persons with chronic pain and likely should be considered the treatment of choice for persons who are at risk for, or who have chronic pain and disability.

MS. BARRETT: Okay. Thank you very much. Your time has run out.

MR. ESQUIVEL: Okay. Just ten more seconds. One last thing. The -- because a couple people mentioned this, I heard it from the chiropractor, physical therapy. The idea of a prior authorization process for modalities such as acupuncture, physical therapy, chiropractic, a prior authorization process that would allow for a short course of treatment, six treatments

for, for injured workers to see, to assess the therapeutic benefit, that was raised by CHSWC, that was raised by CHSWC.

MS. BARRETT: Is that in your document? Because if it's not, what you might want to do is take --

MR. ESQUIVEL: I have a copy of that CHSWC recommendation and I will leave it with you. I just have one copy, because I'm not sure if it's in that.

MS. BARRETT: Okay. Thank you very much.

MR. ESQUIVEL: You're welcome. Thank you.

MS. BARRETT: Ling Yu Suel, S-u-e-l, or Sun, S-u-n, Ling, Ling. No? Okay.

Carol Mitchell Writon. Is it W-r-i-t-o-n? Oh, Writon, I'm sorry. It's Carol, Carol Mitchell.

CAROL DENISE MITCHELL

MS. MITCHELL: Carol Denise Mitchell. I would like to give this to the lady, my latest book on workers' rights. No charge.

MS. BARRETT: Would you mind saying and spelling your name.

MS. MITCHELL: Yes. My name is Carol Denise Mitchell, and I am the author of "Your Rights. What Employers Do Not Want You To Know."

I'm also an injured worker which precipitated my writing the book. What I would first like to do is

say thanks, Stephanie, Ann, Destie, and Minera.

MS. KROHN: Minerva.

MS. MITCHELL: Minerva. Okay. Thank you for having me, and allowing us all a forum on which we could speak. I would just like just to impart to you how important we all are. You're important. We are important as American workers, and these doctors, I couldn't commend them enough for their technical aspects of what's gone awry or what has gone wrong with these regulatory new rules, whatever, and God bless them for being here to -- to ask you not to implement anything that's ambiguous in scope, even in the most minute form.

Dealing with workers' comp was comparable to the way I felt when I learned there was no Santa Claus. I was really remissed as a young girl because you believe as an American citizen in the things that you're taught as a child. So, of course, that transcends into your adult life when you're told specifically by the human resource department that, when you go into a job, you're going to be treated fairly if you get hurt, and when you find out there's no Santa Claus in the workers' compensation system, it's very demoralizing.

I was hurt on the job in February, 2005, when a

large picture fell on my head, and I didn't want to file a workers' comp case because I had filed one before and I didn't want to go through that again. So, what happened, I was very reluctant to do so, but my symptoms made me report the injury. I was a manager of a large property in Pittsburg, California, and I said, "No way. You're not going to report this injury", but then I met Katie Hurt with John Muir Hospital, and she said I don't care, if you were on the job for two hours, you're going to report this injury. I said, "Please don't let me. I don't want to go back to the workers' comp system and deal with State Comp or any of the insurance funds." And she said, "Well, would you like to be an invalid for the rest of your life and not have any recourse?" It's better to have a minute form of recourse and go through these utilization review boards.

They all have a presumptive notion that we're all out to cheat the system, and that is so wrong. I don't think this woman in this wheelchair is out to cheat a system, nor was that woman that had brain surgery, nor was I, and I'm going to tell you the bitter consequences of what happened to me.

I was very reluctant to file a workers' comp case and, when I took my EEG, the lady that took the EEG

said I was an injured worker but I wouldn't dare file a case because I don't want to deal with the insurance company and the review boards. So, she said I worked through my injury. She said, "Don't you want to work through yours?" And I said, "Yes."

MS. BARRETT: Do you have any comments you would like to make about the proposed regulations?

MS. MITCHELL: Yes, I would. What happened was medical treatment for pain, when a person tells you they're in pain, they really are in pain. And what happened was my head injury rendered that not only was I in pain but I was dying. What they found is, my doctor called me up. The workers' comp -- first of all, the workers' comp insurance company sent me to the wrong doctor for my head injury. They sent me to Dr._Sorenson for a head injury, and the man is a hand doctor. He's not a neurologist, and he treated me so bad and he denied my injury. So, what happened was I will call Becky Insingo (phonetic) of State Compensation Insurance Fund, and I will call her when I knew I could get her attention at 3 o'clock in the morning. I thought it was better to leave a concise message and to call her when I had the pain so I could give credibility to the pain rather than her not answer the phone at all.

So, what happened was Dr._Wong called me and told me, "Carol, we've decided that you need to come in right away. There is a problem with you medically that you need to know about." They found a 4 x 5 centimeter tumor on my throat. That had I not reported the workers' compensation injury, I never would have known that I was dying of laryngeal schwannoma. Only a 113 cases of laryngeal schwannoma have been reported. The utilization review board denied my medication and then, when they finally approved my medication, I found out that none of the state or local hospitals could help me any more. My case was being referred to U.C.S.F. I stand here before you thankful for the persistence of me, and wanting to find out what was wrong with me, and Dr._Katie Hurt at John Muir Hospital that I now live with a disease that cannot be excised from my neck. It's a large tumor. I'm only one of maybe 213 cases of laryngeal schwannoma, and that's why an employee's injury must be taken very seriously.

So, while I was at home fighting the insurance company I wrote this book called "Your Rights. "What Employers Do Not Want You To Know" because I figured, if I was going to die of some foreign illness, that I could leave behind a legacy of truth. Maybe the last

iota of truth that employees can depend on.

Thank you.

MS. BARRETT: Thank you very much. Did Maria Lozado appear?

UNIDENTIFIED SPEAKER: She's just sick. She's an injured worker. She had to leave.

MS. BARRETT: Thank you.

UNIDENTIFIED SPEAKER: Like a lot of them.

MS. BARRETT: Thank you.

UNIDENTIFIED SPEAKER: Yeah. Thank you.

MS. BARRETT: Okay. Wei Wei. W-e-i, W-e-i. Michelle Lau.

MS. LAU: Lau.

MS. BARRETT: Lau. Thank you.

MICHELLE LAU

MS. LAU: My name is Michelle Lau, licensed acupuncturist over 20 years, and also I'm the president of the Council of Acupuncture and Oriental Medicine Associations.

MS. BARRETT: Do you spell your last name L-a-u?

MS. LAU: L-a-u.

MS. BARRETT: It's Michelle with two Ls?

MS. LAU: Yes, Michelle with two Ls. Thank you for the opportunity to address our concern here. Actually I will make it very short because our

representative Sandra has already addressed them, most of the things we want to say. The reason I'm here because the Council of Acupuncture and Oriental Medicine Associations cover about 10 organization of different ethnic group. I mean of profession in southern California and northern California. Most of them their representative they cannot come today. Then I just address their concern that -- make it very brief.

The acupuncture treatment to the injured worker in worker comp systems already almost 20 years. So, we have been benefit a lot of patient, the injured worker, offer the opportunity back to work, but since the past four years we have been working very closely with the DWC, RAND Corporation, and the Legislature, and then we try to see what we can work with the system to improve after the ACOEM Guideline was adopted as the Chairman Guideline. So, in the past two years that we already see that nothing has been changed. Nothing has been improved, and nothing happened. So, the critical problem should not be ignored any more longer because the injured worker need to be treat. As what we heard that some acupuncturist saying that the past two years always they haven't treat any patient. So, you think about

that, we have the ten thousand acupuncture, license acupuncture in all California, the whole California, and every day they might be treating several injured worker, but if all these people did not get the proper treatments for what happened to them, they cannot go back to work.

So, I address this, our concern is we really oppose the decision made with ACOEM Guideline as a permanent guideline, and we really wish the DWC department that could do something after the hearing today after listening so many people's concerns.

Thank you so much.

MS. BARRETT: Thank you very much. Kay Lam.

KAY LAM

MS. LAM: My name's Kay Lam. L-a-m last name. First name K-a-y. I'm sorry. I'm not so much fluent with English.

I am acupuncture doctor, also the supervisor over the California U.S. Certified Acupuncture Association. I'm here. We appreciate the opportunity to talk about really something we have been waiting for so long time in the acupuncture community. We have a group of doctor working really hard since 1985 to legislate a bill, SB899, for the injury worker could get acupuncture treatment. Since 1998 and the law passed

give a the patient, injury workers, the right for acupuncture treatment, give a the injury worker a choice, a more choice of their treatment in California. And since that, the law has been extension for four or five times, and until 2002 Senator Porter's bill give for the permanent for the injury worker to have the acupuncture treatment. So the law, California law, give a the injury worker the right for acupuncture treatment, and all but mostly Legislature and the -- all the Council of California, no question that is the law, but unfortunate since the 2004 the ACOEM Guideline, it's almost they take this right away from this injury worker. The reason is that firstly, the ACOEM Guideline make the acupuncture really unclear. So, make the treating physician, they thought from the ACOEM Guideline, so not going to pay for acupuncture treatment. So, first the patients feel difficult, more difficult to get that info from their treating physician. Even think that before, but as the Dr. Lau, as Dr. Lau mentioned about -- from my office they almost could not have the assurancy to get the authorization. For my practice almost 80 percent of the patients wish the doctors a referral. I cannot get authorization. So, the patient lost this treatment. And just the last week I have for a

patient which she asked the doctor, treating physician, for a referral, but they denied the authorization. So, I say, oh, maybe you try to get a attorney to helping you. So, she went to a attorney's office, and the injury specialty attorney. The attorney could not take her case. Why? They say from the ACOEM Guideline the workers' compensation insurance is not going to pay for acupuncture treatment. So, it is really confusing right now. And from my daily past experience we have been this morning have a more doctors and then afternoon they have more go back to their offices. We have about 50 percent the patient coming to our office is spinal pain patient. I think from like a leg pain or back pain, that kind of pain. Quite a lot of injury. That kind of patient. From my -- since the 20 -- I start practice in 1983 in California. So, longer than 20 years experience. For that kind of patient we have about 80 percent of this patient could get the treatment itself from the different level. Some patient if we treat -- I have been treating this injury patient. Some patient they fully recover. They get back to work. Some, they take out their pain medication addition because, if they taken it all, why could they everyday like they got the pain medication.

Our treatment helping them prevent this kind of pain medication addition to this patient. And some patient from the different level we helping them to have a better ability to handle their job duty, to handle their daily living activity, the living condition.

So, I really like enjoy working with a this patient but why not. I could say almost they just like a doctor (unintelligible). Even the patient come in we should get the doctor before. We did not get this authorization. I am just saying two cases just happen not long time ago. That's the one case. It's a State Comp, State Compensation Insurance Fund, the patient. Get the doctors in before, come to my office with the pain in her leg. So, I write -- I did not make any phone call because they never answer my phone call, the insurance adjuster. So, I write a letter, mail to them, fax it to them, so they have to answer back. Few days later they call me. Oh, your case, I forward you the medical consultation already. I say okay, wait, I have been waiting for about two weeks later, and I get the letter coming with the medical consultant. They say according to the ACOEM Guideline acupuncture is no efficacy of the result or for the treatment.

In our daily practice 50 percent, more than 50

percent patient come in with the pain on their back, and even the, many of the patient they have to pay for this treatment but they still come here. Why? Because the treatment helping them. The treatment is now helping them, but the ACOEM Guideline saying not helping for the spinal pain. And the insurance company, all the California insurance company, deny all the spinal pain patient authorization. And as a medical science spinal pain is a really vague diagnosis. Because the spinal pain has a world of different research. Is it a soft tissue injury or (unintelligible), a joint injury? Each patient's case they will respond to the treatment or not. Each case is an individual for medical science practice. Not -- all that I could say on this one thing. So, that's one case. There's another case just happen in July.

MS. BARRETT: You have about two minutes.

MS. LAU: Okay. We have a pain patient comes in who has seen a doctor before. That's a Hartford Insurance Company. First the insurance adjuster Heide throw the ball to the Kim. So, I write a first letter. I write a second letter to Kim. And they throw the ball to Pamela. So, that's an R.N. When I call the nurse, she cannot have the patient's file. Do not have what the doctor, the treating physician

medical evaluation report, that 12 page report saying recommend a course of acupuncture treatment, page 9. Do not have the file. They say okay. I don't have the patient file. I say you got this referral too. You don't have patient file. So I say okay. I fax this report to you and I write a third letter too. So, she give me the letter back. She said okay, you write a examination and copy the report to Dr. Choi. He cannot give you the authorization. I'll say. That's why his number is so far away.

MS. BARRETT: You have about half a minute.

MS. LAU: Okay. Sorry. So, I talk a little fast that's why. Dr._Choi, you not have the patient file. So, by now the insurance company using the ACOEM Guideline. The first people did not have the patient file, did not see the patient, did not examination the patient. They denied our authorization. So, they put the -- use the ACOEM Guideline to take the patient's right of treatment away. Wish you as a committee should really do something to change this. To give the right back to the injury worker of California. Thank you very much.

MS. BARRETT: Thank you very much. If we can refrain from clapping between each one, it would be helpful.

Is Bill Kristy here?

BILL KRISTY

MR. KRISTY: Hi. My name is Bill Kristy.

MS. BARRETT: Would you mind spelling your name.

MR. KRISTY: K-r-i-s-t-y. And first I wanted to say that I found that acupuncturist -- acupuncture did more than just relieve pain. It greatly aided healing for me. I am an injured worker, and I know many. I am permanently disabled from computer programming with a chronic, very slow healing repetitive strain injury. Objective proof of our injuries can be impossible. So, we don't get the treatment we need if treating doctors we choose are ignored in favor of unfair reforms like ACOEM. The workers' compensation system was created to contain litigation by treating workers. Before the reforms a couple of years ago California workers' comp was already more unfair than almost any other state. Now that we've lost rights to both treatment and litigation, we're worse off than if there were no workers' comp system at all.

MS. BARRETT: Thank you very much. Nancy Keiler.

MS. KEILER: Keiler.

MS. BARRETT: I'm sorry. Nancy Keiler.

NANCY KEILER

MS. KEILER: Hi. Good afternoon. I'm not an

injured worker. My name is Nancy Keiler, K-e-i-l-e-r. And I'm with the California Coalition for Workers Memorial Day, which is a pro-injured worker group. Okay. I was not going to say anything until I got here this morning. Our group has protested with Mr. Zeltzer here in front of this very building half a dozen times, okay, in the last few months. Today we were greeted which the presence of the California Highway Patrol. I think the word hijacked came out of Carrie Nevan's mouth, went to Homeland Security, and came down and was going to bust a bunch of injured terrorists. I ask no reason for this. No reason whatsoever. Okay. There was -- at one point there was more troopers than protesters, and they're armed. Our passion for just and appropriate medical treatment for injured workers is our only weapon. I promise we have no guns. Why were they there? Why were they armed? What danger have we ever been to anyone? What threat have we been? Who is paying these people? We are paying them. And you know that they get time and a half for protests, in San Francisco anyway, so I'm sure -- I'm sure that the California State Highway Patrol gets paid a whole lot of money. I'm addressing the issue.

MS. BARRETT: Okay. Very good.

MS. KEILER: Thank you. And applause does make a point. So, I don't want -- if you all want to applaud, please do. I want my points well made. Okay. I want to know what threat have we been. I want to know who answers these questions. I am a private citizen. I saw ten policemen with cars and arms out there for crippled people. Most of our people were in crutches. Okay. This place -- this police presence only adds to the oppressive climate and to the power of insurance companies and their need to control public dissent. Again, who authorized this? Who authorized -- I want to know as a public citizen, who authorized that, the presence of those police? And I want to know -- I want to know what at the cost today for this police exercise was. You know.

MS. BARRETT: Wait. Before you go any further, do you have any --

MS. KEILER: And who are they protecting? Who are they protecting? I want to know that. I want to know the cost. Who are they protecting? Ms. Barrett, this is part of this meeting.

MS. BARRETT: Actually the meeting is about these proposed regulations.

MS. KEILER: Right.

MS. BARRETT: And you have this opportunity.

MS. KEILER: Right.

MS. BARRETT: You have ten minutes to discuss them.

MS. KEILER: Exactly.

MS. BARRETT: Unfortunately you don't have the right to not discuss them.

MS. KEILER: Okay.

MS. BARRETT: So, if you could stay on point it would be very helpful.

MS. KEILER: Okay. Okay. Well, I just have one more thing. Voltaire said, "It is dangerous to be right when the government is wrong." Okay. And this has been just a completely wrong situation today. It's bogus. It's a fraud. You all sit there with no compassion whatsoever. No compassion, and no answering any questions. And please applaud.

MS. BARRETT: Okay. This name is Y-o-u-n-h C-h-u-n-h. Is that Young Chung?

MS. CHUNG: Yes.

MS. BARRETT: Oh, very good.

YOUNG CHUNG

MS. CHUNG: Good afternoon. My name is Young Chung, c-h-u-n-g. I'm a licensed acupuncturist in California 12 years. I'm a member of the California

Acupuncture Association and the Korean Acupuncture Association in California. Today I am here to -- since I've been practicing acupuncture the last 12 years and also treating worker injury last 11 years and know what I see trend, what is going on here with the workers' compensation case. I like to bring up two cases here for my patients. One, she has been with me since the 199 -- year 2001 referral by orthopedic doctor, and this doctor_also referred by her primary worker injury case doctor_and then second this orthopedic doctor_referred for me for pain management. With acupuncture and because she was a highly allergic to any medication and the doctor treated her best knowledge that acupuncture would be best care for her to control the pain, and it worked. However, this year and since this reform two years ago, three years ago, she's back to her first work injury care doctor, and this doctor, Dr. Foster, in Castro Valley started sending her to me, and this law said 24 visit per calendar year allowed. However, this year utilization review said this -- her injury care is not will help, won't help her case, which your review board doctor was in Mississippi. So, Dr._Foster wrote a letter to utilization review board, and this patient has been under Dr._Chung's care the

last such and such a years has been control the pain by acupuncture treatment.

Now, you are not orthopedic specialty. You're simply family physician. Also I think don't have much acupuncture knowledge in my opinion. Dr. Foster wrote that. And also you have no right to make any California law decision, workers' compensation. So, therefore, should it be allowed this patient to continue to have treatment, this acupuncture? However, still denied. She cannot have this care any more.

Another case. She has injured. She is an Oakland Fire Department employee and has injured this foot and developed neuroma, and she also came to me by referral, her workers' doctor, workers' compensation doctor, for the pain management. However, she also not denied. She -- it usually took her get to me two to three weeks.

MS. OVERPECK: Pause one minute please.

(At this point Ms. Overpeck changed tapes on the recorder.)

MS. CHUNG: Give me some time to read.

MS. BARRETT: Wait.

MS. CHUNG: All right.

MS. OVERPECK: Okay.

MS. CHUNG: So, referral came in. However, waiting period was eight weeks. It used to be two weeks. And also her doctor wrote 12 visit and they cut six visit. And at the six visit I wrote a report to workers' compensation, also same time referring physician. Referring physician requested it another 12 visit. And three months still not hear anything. So, this conclusion is, review board they hired from outside of California. I don't think it's such a good idea for California injured care and the California law. That's my conclusion. Thank you.

MS. BARRETT: Thank you very much.

MS. CHUNG: Thank you.

MS. BARRETT: Did William Zhao come back by any chance? And Liu and Hutchings aren't here? And Musawwir?

DR. SEARCY: So, I think that brings us to the end of our list. Does anybody else -- would anybody else like to speak? All right. Well, thank you all very much for coming today. We will still accept written comments until 5 o'clock today. So, you can still send us comments. And if you have comments outside of the -- these particular regulations, you can also send those to us. We just want to remind you about the Information and Assistance offices and that they're 24

different local offices and every month they give a workshop for injured workers. The -- I've heard very good things about it. We've actually sent our news staff to them and they're getting very good reviews from injured workers that have called us. The list of those offices is over on the table, and they do have monthly workshops for injured workers. So, thank you, and it's free. Thank you very much for coming today.

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C E R T I F I C A T I O N

We hereby certify that the foregoing is a full, true and correct transcript of the proceedings taken by us in shorthand on the date and in the matter described on the first page hereof.

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Barbara A. Cleland
Official Reporter
Workers' Compensation Appeals Board

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Morgan R. Kott
Official Reporter
Workers' Compensation Appeals Board

Date: August 29, 2006